

Evaluation of USAID/Armenia's Social Transition Program (STP)

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Acronyms

AAA	Armenian Assembly of America
ASTP	Armenia Social Transition Program (implemented through the PADCO contract)
BBP	Basic Benefits Package (health services provided by the MOH)
CIG	Clinical Instruction Guide
CRS	Catholic Relief Services
CSR	Civil Status Registry (records births deaths & marriages, is subordinated to the Ministry of Justice)
DHS	Demographic Health Survey
FM	Family Medicine
GOAM	Government of Armenia
HIE	Household Income and Expenditure Survey, conducted annually by the National Statistical Service
HIS	Health Information System
IDP	Internally Displaced Person
ISSC	Integrated Social Services Center, that collocates the activities of RSSCs, SIFs, RELs, and SMECs and allow-s data sharing among these activities. An ISSC is being developed and pilot tested by STP in Vanadzor.
Mergelyan Institute	Computing and information institution of the Government of Armenian, previously a highly regarded resource center of the Soviet Union. Officially named Yerevan Institute for Computer Research and Development (YICRD).
MFE	Ministry of Finance and Economy, responsible for developing overall economic policy, ensuring auditing and reporting standards
MIDAS	Database developed for reporting health finance information from hospitals to the State health Agency
MIHTC	Milwaukee International Health Training Center
MOH	Ministry of Health
MOJ	Ministry of Justice, responsible for registering births, deaths and marriages through the CSR
MOSS	Ministry of Social Security
MSR	Ministry of State Revenues, responsible for collecting taxes
MOTC	Ministry of Transportation and Communications
NEMROUT	Computer and information center created through ASTP for the Ministry of Social Security.
NGOC	The Center for NGOs – funded through a USAID/STP Cooperative Agreement with AAA
NIH	National Institutes of Health, where nurses and physicians receive post-graduate education
NSS	National Statistics Service
PADCO	Planning and Development Collaborative, Inc (USAID’s principal contractor under the STP)
PARNAS	Database being designed for personified reporting by enterprises to the Social Insurance Fund
PAROS	Database of low income families used to administer the Poverty Family Benefits system
PFB	Poverty Family Benefit
PHC	Primary Health Care
PN	Personal (Identification) Number
PSP	Parent School Partnership (a technique utilized by CRS)
QA	Quality Assurance
RELS	Republic Employment and Labor Service, responsible for administering unemployment insurance benefits and providing job and training information -- subordinated to the MOSS-there are 51 RELS offices nationwide
RSSC	Regional Social Security Center – there are 54 local RSSCs through which social services are delivered to the population of Armenia
SAD	Social Assistance Departments of the Marzpetaran
SCF	Save the Children
SHA	State Health Agency
SIC	State Insurance Commission
SIF	State Social Insurance Fund, which is administratively independent (but must follow MOSS policy), responsible for

collecting payroll contributions and for distributing mandatory insurance benefits including old age, survivor, and disability pensions, and many small social benefits such as childcare benefits to mothers caring for young children, funeral allowances-there are 54 SIF offices nationwide

SMEC	The Social Medical Expertise Commissions which assess the degree of disability
SMU	State Medical University, where physicians are trained
SRC	Securities Regulatory Commission
SSIF	State Social Insurance Fund
STP	USAID/Armenia's Social Transition Program
UMCOR	United Methodist Committee on Relief
VAT	Value Added Tax
WL	World Learning, a member of the STP program
YICRD	Yerevan Institute for Computer Research And Development (Mergelyan Institute)
YSU	Yerevan State University

International Entities

DFID	Department for International Development of UK
EBRD	European Bank for Reconstruction and Development
IDA	International Development Agency (World Bank)
IBRD	International Bank for Reconstruction and Development (World Bank)
IMF	International Monetary Fund
TASIS	European Union Technical Assistance Program for the CIS
TNO	Netherlands Organization for Applied Scientific Research
UNDP	United Nations Development Program
USAID	United States Agency for International Development
WB	World Bank (International Bank for Reconstruction and Development)
WFP	World Food Programme
WHO	The World Health Organization

Executive Summary

The Social Transition Program (STP) is USAID/Armenia's strategy and program to provide assistance to the population of Armenia in the social and health sectors during the five-year strategic plan period FY1999 – FY2003. The objectives of the STP are to meet the immediate social and health care needs of the most vulnerable Armenians in the short term, while establishing the basis for sustainable and effective social insurance, social assistance, and health care systems. The STP has four interrelated components:

- Establishing the foundations for sustainable social insurance systems through developing governmental institutional capacity, preparing the legal and regulatory framework for these systems, and establishing appropriate information systems;
- Improving the efficiency and effectiveness of the government in providing social assistance and primary health care through clarifying the government's role for the provision of social assistance and health care, restructuring the provision of primary health care, increasing the government's ability to plan, regulate and supervise, better targeting, and improving public information and public awareness;
- Developing alternative mechanisms for providing social services and primary health care through strengthening local NGO and service provider capacity and pilot testing new approaches to addressing needs; and
- Direct provision of humanitarian and social services and providing short-term employment through public works programs that meet community infrastructure needs.

The STP encompasses all of the activities in Armenia in the social and health sectors carried out by USAID and its contractors and grantees, including PADCO, Abt Associates, American International Health Alliance (AIHA), AMEG, Counterpart, QED, MACRO International, PRIME II/Intrah, Carelift International, Armenian Assembly of America (AAA), Catholic Relief Services (CRS) (with Armenian Caritas), Save the Children Federation (SCF), United Methodist Council on Relief (UMCOR) (with Mission Armenia).

The STP strategy incorporates three underlying approaches:

- *Integration* of reform programs and activities in the social and health sectors;
- *Linkage* of the short-term relief activities and long-term reform and development activities; and
- *Implementation* of the experience and lessons learned in other former Soviet republics that have faced problems and undertaken reforms similar to Armenia.

This report has five sections. Section I is an *Introduction*. Section II, *Background*, discusses poverty in Armenia, USAID and other donor programs prior to 2000, USAID's FY 1999-2003 strategy for Armenia, and the objectives and strategy of STP. Section III presents *Findings* in three sections: the social sector, health, and NGO service delivery. Each section describes what has been done to achieve STP's objectives, problems encountered, constraints, and gaps. Section IV presents *Conclusions*. Section V contains *Recommendations*. The following sections summarize the assessment team's principal conclusions and recommendations.

Conclusions

- **Improving Armenia's Social Safety Net**

Reform of Social Insurance and Social Assistance. STP has contributed to the achievement of considerable progress in establishing the foundations for sustainable pensions and poverty benefits and improving the efficiency and effectiveness of the GOAM in providing social insurance and assistance. Most progress has been achieved in improvement of capacity of existing government social insurance and social assistance systems – the state pension system and the Poverty Family Benefit. There is considerable uncertainty about the pace of development of non-governmental institutions needed for

increased individual and employer provision of social insurance and benefits, including financial markets, insurance markets, and corporate governance. The momentum and effective working relationships between key STP partners and MOSS bode well for the future. The key issue for USAID in the coming year is adequate support for the national implementation of the Personal Number (PN) system.

Reform of the Health Sector. STP has provided valuable assistance in the development of legislation, regulation and policy; helped to create and test improved information systems; and provided training to enhance the skills of a variety of personnel, particularly at pilot sites. Nevertheless, progress toward establishing the basis for an effective and efficient health care system has been modest. In part this is a reflection of the somewhat strained relationship between the Ministry of Health and the prime contractor, PADCO. If PADCO and the MOH are able to resolve their differences over the steps to be taken toward reform and to increase the implementing capacity of the MOH, significant progress can be achieved in the future. The AIHA Partnerships Program, PRIME II and MACRO programs appear to be working as planned and are likely to achieve their respective objectives.

Providing Immediate Assistance to the Needy. By helping MOSS target the Poverty Family Benefit, PADCO assistance helped to channel GOAM support to the most needy Armenians. NGO programs are generally well targeted and effectively provide assistance to needy Armenians. Judged by the large number of beneficiaries, the overall impact appears to be quite significant. STP programs administered through CRS/Caritas, SCF and UMCOR/Mission Armenia have reached thousands of vulnerable Armenian families, providing important social, health and nutritional benefits and providing limited employment opportunities. The large number of STP beneficiaries is, however, only a fraction of the needy. The impact of these USAID programs might be increased through greater reliance on Armenian NGOs, but these institutions will require strengthening before they can take on the responsibility of implementing USAID programs.

- **Implementation and Sustainability**

Social Insurance and Services. The Ministry of Social Security, the National Statistical Service and the Securities Commission are enthusiastic about the reform program and want to maintain its momentum. However, the willingness and ability of the government to provide adequate resources to implement nationwide systems that are being developed and piloted is uncertain, including information systems, the Personal Number system, and Integrated Social Service Centers. The ability of the government to maintain facilities and to sustain all the new information systems is also uncertain.

Health Care. Stakeholders throughout the Armenia health care system resist important elements of the reform program, particularly restructuring the system to emphasize primary care and general practice. It is not clear that all of the leadership in the health care system agree with the STP approach and objectives. Until greater understanding and clarity of objectives, approaches, and roles have been achieved, sustainability of the reform process will be uncertain.

NGO Programs. STP's NGO programs will be sustainable only with continuing support from the government, donors or the local communities. NGO social and health programs are almost never sustainable without external support.

- **Integration**

STP's integration of the work on social sector and health sector reforms has been rewarding. Both sectors benefit from information systems that are consistent and can be linked, assistance in the development of a consistent legal framework, training in common skills, and use of the same survey information. However, the integration of social sector and health sector work has complicated management and may have contributed to the somewhat limited progress in the health sector. Creating and managing an effective team to work on both sectors has proven difficult for the PADCO consortium, as has dealing with two

Ministries with different needs and styles. The increased complexity of the management structure within the program has also placed a burden on the subcontractors. Except for the various institutions working under the PADCO contract, the U.S. partners under STP function largely independently of one another, as do the MOH and MOSS. The lack of integration of these institutions, however, does not appear to have adversely affected the performance of the individual partners.

- **Linkages**

There is little linkage among the STP partners working on reform and capacity building at the national, regional or ministry level (PADCO/Abt and PRIME II) and NGOs engaged in humanitarian relief efforts, or in their program elements. A number of the NGO programs test innovative models or program elements that might provide valuable lessons about cost-effective methods to deliver social and health services. STP has supported efforts to encourage collaboration between NGOs and government, but these do not appear to have had a significant effect on the development of Social Partnership. The relationship between NGOs and the government ministries is typically not close. STP's contribution to developing viable Armenian NGOs has been modest. The NGO programs supported by STP are most appropriately considered humanitarian assistance rather than development programs, although most have a social or economic development component.

- **Management Issues**

USAID's Oversight Role and Implications for Staffing. Mission personnel have been stretched to deal with the large number of actors and the complexity of the program. In part, this reflects the Mission's level of process oversight. USAID personnel review and approve a very large number of reports, documents, and spending decisions included in previously authorized work plans and budgets. At the same time, the Mission provides limited technical oversight of contractor activities.

The USAID-PADCO Contract. The PADCO contract is overly rigid, with too many deliverables. In an undertaking as complex as social sector and health sector reform, it would be appropriate to build more flexibility into the contract for technical assistance services.

- **Decentralization**

STP has supported the GOAM's stated policy of decentralization by working with marz governments in those marzes selected for pilot activities. Thus far, however, the GOAM has not backed up its policy of decentralization with budget resources, so it has been difficult for local and regional governments to undertake activities on their own.

- **Program Gaps**

The most important gap in the STP social sector reform program is the lack of programs or initiatives concerned with employment, unemployment and the labor market. STP has provided no support to development of social services and only modest support to the training of social workers.

Recommendations

- **The PADCO Contract**

USAID should exercise its option to extend the PADCO contract by two years to permit the contractor to continue its activities in the social sector. PADCO's activities implemented jointly with the MOSS are progressing well, and relationships are strong and effective. Changing contractors or personnel at this time would be disruptive and impede progress. The extension of PADCO's health sector program should

be contingent upon (1) the satisfactory resolution of the current difficulties between the MOH and the contractor and (2) the key parties (including USAID) being satisfied that the technical assistance provided will lead to concrete actions, i.e., that the MOH will have the interest and capacity to implement the programs to which PADCO is contributing. PADCO should strengthen its health team, recruiting if possible a senior health economist.

- **Mission Management**

Future Mission contracts and cooperative agreements should provide more discretionary authority to the recipient, limit prior Mission approvals, and hold contractors and grantees responsible for results. USAID should provide more *technical* oversight of reform activities, through the use of intermittent short-term expert consultants to provide an independent expert review of recommendations and progress.

- **Implementation**

USAID, the World Bank, the Ministry of Finance and Economy, and the MOSS should clarify and guarantee adequate financing of the costs of the national implementation of the PN system and of personal social insurance accounts over the next five years. This should include capital costs, start-up costs and operating costs. USAID should discuss with the World Bank the establishment of conditionality that would ensure that the GOAM does not cut the social and health sector budgets, undermining the reforms being put into place.

- **Priorities for Future Programming**

- Incorporate employment and labor market programs into future STP programs.
- Support development of training programs for social workers as a component of STP, offering such programs to a wide variety of public and private sector personnel dealing with social and health services.
- Assist MOSS to develop additional Integrated Social Service Centers (ISSCs). ISSCs should be piloted in marzes other than Lori, where the one current ISSC is being piloted.
- Explore the possibility of developing new ISSCs within underutilized MOH polyclinics.
- Consider an expansion of Mission Armenia's integrated social and health service model.
- Continue and redouble efforts to strengthen Armenian NGOs. A condition of any assistance to a U.S. PVO should be that it incorporate a serious component directed toward the development of one or more local partner organizations. This component would include a time-phased plan to bring that organization to the level at which USAID would consider providing grants directly to it.

STP Assessment Report

I. Introduction

The Social Transition Program (STP) is a complex, multi-faceted five-year program created and funded by USAID/Armenia. STP has two principal objectives:

- To assist the Government of Armenia (GOAM) to meet the immediate social and health needs of the most needy Armenians,¹
- To establish the basis for sustainable and effective social insurance, social assistance and health care systems.

STP encompasses a wide variety of programs implemented by GOAM institutions, U.S consulting firms, and U.S. and Armenian non-government organizations (NGOs). Implementation activities have been underway for about two years. (A more complete description of STP is provided below.)

The purpose of this assessment is to review the progress the STP achieved in its first two years of operations. The assessment is to determine whether the assumptions underlying the STP have proven to be correct and whether the program is progressing satisfactorily. The assessment is intended to help USAID/Armenia make decisions about the extension of some on-going activities and about its strategy for the Fiscal Year (FY) 2004-2008 period.

Organization of the Report. This report is divided into four additional sections. Section II presents a brief description of poverty in Armenia and its causes, USAID and other donor efforts to address poverty issues prior to 2000, USAID's FY 1999-2003 strategy for Armenia, and the objectives and strategy of STP. This section also describes the STP implementing mechanisms and defines key STP concepts and terms that will be discussed in the report.

Section III presents the assessment team's findings. The presentation of findings is divided into three sections: the social sector, health, and NGO service delivery. Each section will describe what has been done to achieve the STP's objectives in that area, problems encountered, constraints and gaps.

Section IV presents the assessment team's conclusions about the issues that USAID requested that the team address. In most cases, the explanation of these conclusions is brief, as the facts leading to them have been presented in the previous section.

Section V presents the team's recommendations.

¹ The most needy are defined as those Armenians not able to meet their basic health, nutrition and shelter needs.

II. Background

A. Poverty in Armenia

Under the Soviet Union, Armenia was a reasonably well-off industrialized republic, producing goods for other parts of the Soviet empire and receiving many other industrial and agricultural goods in return. The standard of living was not high by U.S. or Western European standards, but Armenia certainly qualified as a middle-income region. Although salaries were modest, families benefited from stable employment, highly subsidized housing and guaranteed social and health services.

In the 1988-1993 period Armenia suffered from three devastating economic blows. The shock waves from these events were felt in every segment of the economy, causing Armenia's real GDP to contract between 1990 and 1993 by 53 percent.

The first blow to Armenia's relative prosperity came in 1988, when an earthquake devastated a large region of the country and killed 25,000 people. The earthquake damaged a great deal of public infrastructure, reduced industrial production 40 percent, and left an estimated half million Armenians homeless.

In 1991 the breakup of the Soviet Union destroyed the system of trade and finance among the former Soviet republics upon which Armenian industry depended. Many Armenian factories shut their doors, leaving tens of thousands of workers unemployed. Most construction was halted, leaving still others unemployed.

As the Soviet Union was breaking up, Armenia's conflict with Azerbaijan over Nagorno-Karabakh led to the displacement of large numbers of Azeris previously living in Armenia and in the parts of Azerbaijan occupied by Armenia and the inflow of ethnic Armenian refugees from Azerbaijan. The border with Azerbaijan was closed, and because of the unresolved conflict, Turkey imposed a trade embargo against Armenia, closing off Armenia's best trade route to the world. The collapse of the Soviet Union greatly magnified the importance of the Turkish trade embargo, as Armenia's normal trade flow to the north stalled.

Since 1993 real GDP growth has averaged about six percent per year. By 2001 real GDP was equal to about 74 percent of the 1990 level. The current growth is driven primarily by recovery from the severe contraction of 1990-1993. It is not based on any substantial changes in either enterprise behavior or investor attitude that could be considered longer-term sources of economic expansion, export growth and job creation.²

While average real wages have increased since 1993, the increases have primarily benefited workers in a few relatively well-to-do and relatively small sectors of the economy that employ a small proportion of the labor force. The total wage bill in industry and agriculture, sectors that in 1999 employed 58 percent of workers, has declined. The growth without poverty reduction which occurred between 1994 and 2000 was related to the relatively narrow sectoral and enterprise base of growth, when reduction of traditional enterprises had a stronger impact on employment and incomes than expansion of new enterprises.

During this period income inequality has also increased significantly. The Gini coefficient, a widely used indicator of income inequality, is highest in Armenia among a large group of observed transition economies.³ In 1999 the average income of households in the top 20 percent of the income distribution was 32 times greater than those in the bottom 20 percent. Average consumption expenditures of

² World Bank, *Armenia: Growth Challenges and Governmental Policies*, Vol. II, November 2001, p. 1.

³ Republic of Armenia, *Interim Poverty Reduction Strategy Paper*, Yerevan, March 2001; National Statistical Service, *Social Snapshot and Poverty in the Republic of Armenia*, Yerevan 2001.

households in the top fifth were almost seven times greater than the bottom fifth. Income is also very unequal by region. In 1998-99 average retail sales per person in Yerevan was 2.4 times greater than the average for the country.⁴

Until 2001 there was little reduction in poverty, as shown in Table 1.

Table 1
Poverty Rates in Armenia⁵

	Poor	Very Poor
1996	54.7	27.7
1999	55.1	22.9
2001	50.9	14.9

Source: National Statistical Service of Republic of Armenia

The reduction in poverty rates between 1999 and 2001, and especially the percent of the population classified as very poor, is attributed to the continuing economic growth and the improved targeting of the Poverty Family Benefit.⁶

Poverty is highly correlated with unemployment. Among the unemployed, 64 percent were classified as poor in 1999; 29 percent were very poor. The official unemployment rate was 11.2 percent in 1999 and 9.2 percent in August 2002 (137,000 persons). According to the Integrated Household Survey of Living Standards, in 1999 27.3 percent of the labor force was unemployed.⁷

Armenia's poverty is sometimes characterized as "transient" and "shallow" in nature. "Transient" refers to the fact that families move in and out of poverty, sometimes several times in a year. With little savings to fall back upon, a family's current consumption is highly dependent on whether a family member has even a temporary job, receives a remittance from abroad, or faces the need for unusual expenses (e.g., illnesses). Poverty is also characterized as "shallow" because few families are without some form of shelter, and there is no evidence of acute malnutrition or starvation.

Armenia's social safety net was overwhelmed by the economic crisis. The real value of unemployment benefits and old-age pensions plummeted, and payments were often suspended or delayed. With government revenues down, it became impossible to pay healthcare providers and to provide benefits to all of the needy. Health workers have substituted fees, often paid informally to the providers, for unpaid salaries. This has raised the out-of-pocket cost of health services, causing many families to self-treat to avoid payment.

B. Humanitarian and Economic Assistance

Armenia's plight has been met with a considerable outpouring of financial and humanitarian support, in part through the direct or indirect efforts of the large Armenian diaspora. Direct assistance from Armenians living in other countries has included everything from cash transfers to family members to the provision of food and clothing to the construction of a cathedral marking the 1300th anniversary of the arrival of Christianity. About US\$ 250 million (equivalent to 12 percent of GDP) is privately transferred annually to Armenia. A particularly important current program is the massive public works funded by a wealthy Armenian American. A grant to the Armenian government of \$150 million (equivalent to seven

⁴ National Statistical Service, *op. cit.*, p. 12.

⁵ Poor refers to households whose per capita consumer expenditures are less than the minimum consumer basket. Very poor refers to households whose per capita consumer expenditures are less than the minimum food basket.

⁶ Hracha Petrosyan, National Statistical Service, interview, July 29, 2002.

⁷ National Statistical Service, *op. cit.*, p. 37.

percent of GDP) to rebuild the country's infrastructure has put thousands of Armenians to work, at least temporarily.

International and bilateral donors have also been active in Armenia, providing assistance in many sectors. Donors that had been working actively on social insurance, social assistance, and health sector reform at the time the STP began in mid-2000 included the World Bank, UNICEF, UNFPA, WHO, EU/TACIS, DFID, the Dutch economic aid program, as well as several NGOs. TACIS support for the Ministry of Social Security (MOSS) Labor and Employment Service has been an important complement to the work that USAID and the World Bank have carried out on other elements of the social safety net. The IMF sent a social safety net technical assistance mission in 1993, and 17 technical assistance missions during 1998-2000 in tax and fiscal affairs, monetary policy, foreign exchange, banking and statistics.

The World Bank has been the major donor (other than USAID) involved with social insurance systems, social assistance and health care reform. The Bank's activities have included the following:

- Advised the MOSS concerning the development of a plan for reform of the state pension system, which was reflected in the decree on state pension reform issued in December 1999;
- Supported the development of a personal identification number system, to permit the development of individual pension accounts;
- Assisted efforts to improve the targeting of the Poverty Family Benefit;
- Supported the first household surveys of income and expenditures in 1996, 1998, and 1999;
- Provided assistance to health care reform, including optimization and privatization of health care facilities, reorienting the health care system toward provision of primary health care, training in family medicine, improving management information systems, and planning for the introduction of national health insurance; and
- Funded the Social Investment Fund, which was used for community-based infrastructure projects, similar to projects funded by USAID and implemented by NGOs.

As of December 31, 2000, the World Bank had extended total credit to Armenia of \$607 million, of which \$430 million had been disbursed. The International Monetary Fund had approved credits to Armenia of 153 million SDR, of which 123 million SDR had been drawn.

At the beginning of the STP there was some duplication and overlap between World Bank programs and the STP. These problems were resolved during the first year of the STP, and the Bank and USAID have worked together in a complementary way.

Annex C, Table 1 summarizes major other donor activities up to the beginning of the STP in mid-2000.

C. USAID Assistance to Armenia

USAID assistance began in 1992. The focus of the program in the early years was on humanitarian relief, much of it provided through U.S. private voluntary organizations (PVOs).

Beginning in 1995, USAID's program began to shift toward programs designed to build the policy and institutional basis needed for a competitive, market-based economy. USAID programs addressed the need for economic and financial reforms, supporting mechanisms to encourage and to protect investment and to establish the rule of law in business and in other areas of society.

In 1998-99, the USAID Mission embarked on an analytical and planning exercise to develop a new strategy for the coming five-year period. The resulting Strategic Plan for Fiscal Years⁸ (FY) 1999-2003 had six major components or Strategic Objectives (SOs):

- Growth of a Competitive Private Sector (SO 1.3)
- Investment Increased (SO 1.4)
- A More Economically Sustainable and Environmentally Sound Energy Sector (SO 1.5)
- Laws Enforced and Adjudicated Impartially (SO 2.2)
- Increased Citizen Participation in the Political, Economic and Social Decision-Making Process (SO 2.1)
- A Strengthened Social Safety Net (SO 3.2)

D. Strengthening Armenia's Social Safety Net: STP Objectives and Strategy

The inclusion of SO 3.2 (later renamed SO 3.4) in USAID/Armenia's strategic plan reflected a realization that Armenia's economic recovery would not be easy or quick and that the growth that was occurring was leaving many Armenians behind. Unemployment and poverty remained at very high levels. As Table 1 indicates, 55 percent of the Armenian population was considered poor and 23 percent were considered very poor in 1999. Many families faced daily challenges in obtaining adequate food and shelter. The government's ability to provide a social safety net, including cash payments and services for the elderly, disabled, and unemployed, was greatly over-extended. The government health system had deteriorated badly. The key Government of Armenia (GOAM) institutions, the Ministry of Social Security (MOSS) and the Ministry of Health (MOH), lacked sufficient financial and human resources to meet current needs or to restructure their systems to meet the future needs of a new political and economic environment.

USAID's strategy for strengthening Armenia's social safety net is incorporated in the STP. STP attempts to address the population's immediate need for social and health care services while simultaneously establishing the basis for sustainable and effective provision of such services over the longer term. The STP has four interrelated components:

- Establishing the foundations for sustainable social insurance systems through developing governmental institutional capacity, preparing the legal and regulatory framework for these systems, and establishing appropriate information systems;
- Improving the efficiency and effectiveness of the government in providing social assistance and primary health care through clarifying the government's role for the provision of social assistance and health care, restructuring the provision of primary health care, increasing the government's ability to plan, regulate and supervise, better targeting, improving public information and public awareness;
- Developing alternative mechanisms for providing social services and primary health care through strengthening local NGO and service provider capacity, and pilot testing new approaches to addressing needs;
- Direct provision of humanitarian and social services and providing short-term employment through public works programs that meet community infrastructure needs.

USAID awarded a contract to implement activities to achieve all of the first two components and part of the third. Direct provision of humanitarian and social services in the short-term was to be implemented primarily through experienced, U.S.-based non-governmental organizations (NGOs), which could mobilize quickly and deliver services directly to the most needy. STP would assist the GOAM to restructure its social and health programs using U.S. contractors with specific expertise in those areas.

⁸ The fiscal year for USAID begins on October 1. Thus, USAID's five year Strategic Plan for FY 1999-2003 took effect on October 1, 1998 and will end on September 30, 2003.

1. Key Approaches and Assumptions

Two key approaches incorporated into the STP strategy are “integration” and “linkages.” These terms have specific meanings in the STP context.⁹

Integration. An explicit aspect of the design of the STP was to take a joint and integrated approach to reform and capacity building in the social and health sectors. The strategy was informed by recognition that the problems and issues arising in both sectors were closely interrelated, that programs in both sectors targeted largely the same vulnerable population, and that inadequacies or improvements in assistance or services provided in one sector would affect services in the other sector. The integration strategy was based on the belief that reform and development in both sectors involved many of the same basic elements: preparation of an appropriate policy, legal and regulatory framework; improved capacity to plan, supervise, finance and administer systems of service and benefit delivery; development of information systems; and public education. The integrated approach also sought to address issues raised by the limited organizational capacity of the two key GOAM ministries involved, the Ministry of Social Security and the Ministry of Health, and to maximize the effectiveness of the limited technical assistance and investment resources available. To help facilitate an integrated approach to reform in the social and health sectors, USAID awarded a single prime contract for the major reform and capacity building technical assistance in the social and health sectors in the expectation that that assistance would be provided by a coordinated team of advisors. The same or similar technical assistance approaches and expert advisors addressing these elements in one sector could also address them in the other sector. Sequencing of reform programs and projects could be designed to take maximum advantage of activities implemented in one sector for the other sector. Lessons learned and experience gained working on issues in one sector could be applied to improve assistance in the other sector. The STP strategy anticipated that reform initiatives and capacity building would be pursued jointly for both sectors in hopes that there would be synergies or efficiencies to be gained from an integrated approach to both sectors.

Linkages. By “linkages,” STP means tying together its short-term relief activities and its long-term restructuring and development activities.¹⁰ STP’s premise is that structuring these various activities so that they support or leverage one-another will increase the overall impact. STP’s concept of linkages has three aspects:

- *Pilot-testing alternative mechanisms for delivering social and health services.* While many of the NGO efforts were to provide direct assistance to the most vulnerable, these short-term NGO-based services were to be provided in such a way as to pilot-test cost-effective methods for service delivery and, to the extent possible, to determine the best method to finance such services.
- *Strengthening Armenian NGOs.* STP’s strategy also anticipated that Armenian NGOs would participate in the implementation of this program and be strengthened in the process. A specific NGO-strengthening program was also funded as part of the program. Strengthened Armenian NGOs would be prepared to become future providers of social and health services,

⁹ The assessment team’s understanding of these terms is based primarily on its reading of the Mission’s Strategic Plan for FY 1999-2003 (March 1999), the Monitoring, Evaluation, and Design Support (MEDS) project report (Becker, *et al*, December 1999), the STP Concept Paper (December 20, 1999), the PADCO contract and other documents, and interviews with key USAID, contractor, and other partners’ personnel. These interviews indicate that these concepts are not well understood. Some USAID staff disagreed with these definitions. (See footnote 10 on the following page.) Most contractors and grantees are focused on their own activities and not on the broader STP strategy to which these terms apply.

¹⁰ The term “linkage” in USAID parlance often has a considerably broader meaning. Indeed, some USAID personnel involved in the implementation of this program view the term more appropriately defined as including STP’s “linkages” to other donor activities and to other USAID strategic objectives. The assessment team believes that those linkages are important and comments upon them in other sections.

i.e., they would become part of the new Armenian social safety net, supplementing improved government systems.

- *Improving GOAM-NGO collaboration.* Finally, the collaboration between NGOs and government during the STP would work toward establishing effective long-term collaboration between Armenian NGOs and the GOAM. This “Social Partnership” would also help to strengthen Armenia’s social safety net over the long-term.

Although not so prominent as *linkages* and *integration*, STP also incorporated a focus on *implementation* (as opposed to study and analysis) in the efforts to help Armenia to develop sustainable and cost-effective social insurance and social and health care services. STP’s focus on implementation stems from the planners’ assumption that Armenia could use the experience of other former Soviet republics to “leapfrog” over what might otherwise be years of data collection, study and analysis. This assumption was based on the understanding that Armenia’s social and health sectors’ organization and policies and their problems were not unique; those systems were nearly identical to the systems inherited by other newly independent former Soviet states. The analysis already done of those problems in other newly independent states and the reform experiments completed would thus allow Armenia to short-cut the normally long process preparatory to reform. The reforms that Armenia needed would be very much like the reforms that had been attempted in the 1990’s in other former Soviet republics. Several of those reform efforts had received extensive USAID-financed technical assistance, and some appeared to be quite successful. Of particular interest were the pension and social assistance reforms being carried out in the Ukraine and the health insurance and health services reforms being carried out in Kyrgyzstan.¹¹

2. STP Partners

USAID-financed STP programs are implemented through eight contracts and cooperative agreements with U.S. organizations. These agreements may be roughly divided as follows into longer-term (macro) activities and shorter-term (micro) activities.

Partners primarily involved in helping the GOAM to build efficient and effective social and health care systems:

- The American International Health Alliance (AIHA)
- MACRO (Contractor for the Demographic Health Survey or DHS)
- PADCO and its sub-contractors: Abt Associates, AIHA, AMEG, Counterpart and QED
- PRIME II/Intrah
- Carelift International

Partners primarily involved in helping to provide immediate relief to vulnerable Armenians:

- The Armenian Assembly of America (AAA)
- Catholic Relief Services (CRS) (with Caritas)
- Save the Children Federation (SCF)
- The United Methodist Council on Relief (UMCOR) (with Mission Armenia)

The assessment team’s analysis of USAID/Armenia’s STP budget suggests that about 70 percent of its resources are devoted to longer-term reform and capacity-building activities and 30 percent to shorter-term relief and development activities. These two groups are sometimes referred to as STP’s “macro” and “micro” activities.

¹¹ USAID/Armenia awarded the major STP contract to a consortium that included the two contractors, PADCO and Abt Associates, which had provided technical assistance to those programs in Ukraine and Kyrgyzstan, respectively.

The number of Armenian counterparts is considerably larger. The most important counterparts are the Ministry of Social Security (MOSS) and the Ministry of Health (MOH). Important counterparts include the following:

- Abovian RSSC PN Pilot Project
- Local officials and civic leaders
- Ministry of Finance and Economy
- Ministry of Health (MOH)
- Ministry of Justice (MOJ)
- Ministry of Social Security (MOSS)
- National Institute for Labor and Social Research
- National Statistical Service (NSS)
- Nemrout Center
- Securities Commission
- Social Insurance Fund (SIF)
- Lori Marzpet Offices
- Vanadzor Integrated Social Services Center (ISSC)
- Yerevan State University (YSU)
- Yerevan Institute of Computer Research and Development (YICRD, Mergelyan Institute)

This list is by no means complete; there are dozens of other institutions that contribute to the achievement of the program's objectives.

E. Key Assessment Issues and Methodology

This assessment¹² is essentially a review of the STP strategy. The Mission's scope of work for this assessment requires, for example, that the assessment team report on whether integration, linkages and other key STP strategies have been successful, on whether the program is likely to achieve its anticipated results, on management issues impeding progress, on the adequacy of resources, on gaps in the program's design and on other cross-cutting issues. This assessment is not an evaluation of the various USAID contractors and grantees, although addressing the issues mentioned above has required that the team review and comment upon the progress of the various programs and on obstacles in key areas. (For a full understanding of the assessment team's assignment, see Annex A, Scope of Work.)

The assessment team began its work in Washington, D.C. the week of July 8, 2002. Members participated in team planning meetings and met with USAID officers familiar with the STP program. The team also met with several of the STP contractors and World Bank experts. The team also reviewed STP documents that USAID provided.

The team began its work in Armenia on July 18. During its four weeks in Armenia, the team met with more than 150 people who are involved with the STP. The team conducted interviews with USAID/Armenia officers and with senior members of the PADCO team, as well as personnel from all of the STP partner organizations, including other contractors and grantees (those with cooperative agreements under STP). It interviewed dozens of Armenian counterparts in the MOSS, the MOH, the Nemrout Center, the National Statistical Service, the Securities Commission, regional and local officials, doctors and nurses in facilities being used as pilot sites, university professors, and volunteers participating in community projects. (Annex B provides a list of individuals interviewed.¹³)

¹² The authors will henceforth refer to their work and this report as an assessment rather than an evaluation.

¹³ This list is incomplete, as it was often not possible to obtain the names of every individual in meetings, particularly in field visits where the number of physicians and nurses and community volunteers was often very large. The team apologizes for any oversights.

The team visited three MOH polyclinics in Vanadzor (Lori marz) where project activities are taking place, the Vanadzor site of the pilot MOSS Integrated Social Service Center (ISSC), a MOSS-operated orphanage in Vanadzor, the Nemrout Center, the Actuarial Sciences Center at Yerevan State University, SCF community projects in Dsegh (Lori) and Sevan (Gegharkunik), a CRS school feeding site in Dprabak (Gegharkunik), an UMCOR/Mission Armenia community center for the elderly and disabled in Yerevan, the Abovian pilot site being used for the introduction of the Personal Identification Number (PN), and a variety of other institutions. In the course of these meetings, the team acquired dozens of additional documents, which it has reviewed.

At the end of its third week in country, the assessment team organized a three-hour workshop attended by 35 individuals working on some aspect of STP, including almost all of the key partners and counterpart organizations. The purpose of the workshop was to provide the participants an opportunity to hear the assessment team's preliminary findings and conclusions and to allow those participants to provide feedback to the team.

The team completed its work in Armenia on August 14 with a briefing on conclusions and recommendations for USAID/Armenia personnel. The team completed its draft report after returning to the U.S. and transmitted that report to the Mission at the beginning of September. The Mission provided feedback to the assessment team, and the final report was submitted to the Mission in early October.

III. Findings

Part III is divided into six sections. Sections A through C provide an overview of findings regarding STP performance, respectively, in the reform of the social sector, the reform of the health sector, and the delivery of social and health services and short-term employment through NGOs. Section D presents the team's findings with respect to STP's integration concept, and Section E presents the findings with respect to STP's linkage concept. Section F discusses management issues.

A. Social Sector Reform¹⁴

1. Background

At independence in 1991, Armenia inherited the soviet system of social insurance and social assistance. Under the soviet system, there was not a clear distinction between social insurance and social assistance. Most social benefits were paid out of the State Social Insurance Fund (SIF). These include labor pensions, based on work experience and earnings; privileged pensions; social pensions, for those with insufficient work experience; unemployment compensation; maternity leave; sick leave; birth grants; child care allowances; and other benefits. The state pension system was an unfunded pay-as-you-go system relying on relatively high payroll tax collections from state enterprises. It provided comprehensive, relatively generous benefits, including many privileged benefits for workers judged to have worked in especially difficult or meritorious jobs. The normal retirement eligibility age for women was 55 and for men 60. Eligibility for privileged pensions could occur at younger ages.

The severe contraction of the economy and contraction or shutting down of most large state enterprises led to a decline in payrolls and in pension fund and state tax revenues. Faced with a reduced ability to pay pension benefits, the GOAM implemented a significant pension reform law in 1996. The 1996 pension law reduced pension benefits, raised the normal retirement eligibility age, and based the benefit formula entirely on length of service, severing any connection between the pension amount and the worker's earnings. Under the 1996 law (prevailing in August 2002) the retirement eligibility age for men is currently 63½ and for women 58½. These were scheduled to increase, ultimately to reach 60 for women and 65 for men. The monthly pension benefit is calculated as a base amount of 3,000 AMD (\$5.40¹⁵) plus 60 AMD (\$0.11) per year of service. The average pension is currently 5,400 AMD (\$9.73). All workers with the same length of service receive the same pension, regardless of how much they earned during their work lives. A worker with 20 years of service receives a monthly pension of 4,200 AMD (\$7.57), while a worker with 40 years of service receives a monthly pension of 5,400 AMD (\$9.73), only 29 percent more. The average pension equals about 20 percent of the average wage.

Pensions are funded by a tax on payrolls that averages 24 percent, collected from employers. Although workers with higher salaries have much larger payroll tax payments assessed, they do not receive larger pensions, for equal length of service. Many workers perceive the fact that pension benefits bear no relationship to earnings and payroll taxes paid as unfair, and there is no incentive to pay the taxes or to be sure employers pay them on the worker's behalf. Consequently, contribution compliance is very low. Estimates of the share of potential contributions that is not collected range from 10 percent to 50 percent.

¹⁴ This section describes and assesses activities in the social sector carried out under the first two components of the Social Transition Program identified in the *Concept Paper Social Transition Program*, USAID, December 1999, and in Section C – “Description/Specification/Work Statement” of the Request for Proposals for the Social Transition Program and the August 2000 contract between USAID and PADCO. It focuses almost entirely on programs and activities carried out by PADCO and its consultants and counterparts in the GOAM. Some social sector activities are conducted by NGOs. Those are discussed in Section III C of this report.

¹⁵ At the time of this assessment, 555 Armenian drams (AMD) equaled U.S. \$1.00. That exchange rate is used throughout this report.

A government decree on pension insurance strategy in December 1999 initiated a new pension reform process, defining the principles of the reform and establishing a working group to move the process forward. The World Bank provided technical assistance in the development of the pension reform plan, and it follows a model that the World Bank has promoted in many countries. The principles included a three-tier approach to pension reform: (1) a strengthened pay-as-you-go pension system with individual accounts; (2) a mandatory funded contributory system; and (3) a voluntary, non-state contributory pension system.

The economic contraction led the GOAM to consolidate most social assistance payments into a single Poverty Family Benefit (PFB), and to move the financing of that benefit from the Social Insurance Fund to the state budget. The monthly PFB amount is 4,000 AMD (\$7.20) plus 1,500 AMD (\$2.70) per child age 18 or younger. The average Poverty Family Benefit in 2002 is 6,400 AMD (\$11.50). The PFB was initially not well targeted. Many families applied for the benefit, and there were widespread reports of fraud in applications and awards.

Table 2 shows average pension benefits, Poverty Family Benefits, and several other income amounts for comparison.

Table 2
Selected Monthly Benefits and Salaries in Armenia

Benefit Type	AMD per month	U.S. dollars per month
Pensions		
Basic pension benefit (min)	3,000	5.41
Average pension	5,400	9.73
Poverty Family Benefit		
Basic Benefit	4,000	7.21
per child age 18 or less	1,500	2.70
couple + 2 children	6,000	10.81
Average benefit	6,406	11.54
Unemployment benefit		
Laid off	3,900	7.03
Resigned (80% of full benefit)	3,120	5.62
Fired (60%)	2,340	4.22
Monetary assistance	1,560	2.81
Food for Work (800 AMD/day, \$1.44)	17,600	31.71
Teacher salary in Lori marz		
Low	12,000	21.62
High	50,000	90.00
Unskilled worker on SCF project (\$4.09/day)	50,000	90.00
Average wage/month	23,226	41.85

2. Goals

The goal of the Social Transition Program is to meet the immediate social and health care needs of the most vulnerable, while establishing the basis in the longer term for sustainable and effective social insurance and social assistance systems. For social insurance and social assistance, the STP has two closely related components:

- Establish the foundations for sustainable social insurance systems,
- Improve the efficiency and effectiveness of the Government of Armenia in providing social assistance.

The many STP programs and activities designed to establish the basis for sustainable and effective social insurance and social assistance systems have focused on four objectives:

- Reform the existing state pension system,
- Establish framework for nonstate pensions,
- Improve the Poverty Family Benefit,
- Increase governmental institutional capacity to plan, finance, monitor, and administer social insurance and social assistance programs.

The various STP programs to achieve these objectives are implemented under a USAID/Armenia contract with PADCO.

Reform the existing state pension system

The ultimate goals for reform of the existing pension system are to increase the pension benefit amount in order to provide an adequate income to the retired, disabled, or survivor beneficiaries; improve targeting of the pension; and link the pension benefit to the individual's contribution both to improve the perceived fairness and to increase contribution compliance. To help the GOAM achieve these goals, PADCO has carried out activities supporting reform of the state pension in four areas:

- Improve the legal and regulatory framework,
- Improve GOAM institutional capacity to plan, finance and administer the pension system,
- Develop the information management systems required,
- Increase citizen awareness and information about pension reform.

Establish framework for nonstate pensions

Establishment of a viable framework for nonstate pensions has several long-term goals. First, nonstate pensions can augment state pensions to increase the retirement income and improve disability insurance and survivors insurance for those able to contribute, providing greater opportunities for individuals to take responsibility for their economic well-being and reducing the burden on the state system as the population ages in the future. Second, the regulatory and financial markets institutions required for nonstate pensions will provide the pre-conditions required for the introduction of a mandatory, contribution-funded component of the state pension – the second tier envisioned in the 1999 pension reform strategy. The GOAM, in consultation with PADCO advisors, decided that the conditions did not currently exist in Armenia to proceed immediately with the development of a mandatory, individual contribution-funded, second tier of the state pension. Rather, they decided to develop the pre-conditions for a contributory component of the state pension by establishing a framework for contributory nonstate pensions. Third, development of nonstate pensions will help strengthen financial markets and institutions and provide a source of domestic capital for investment. STP activities to support the development of nonstate pensions have focused on the establishment of the legal, regulatory, and policy framework.

Improve the Poverty Family Benefit and social services

The goals of the GOAM are to raise the average benefit level and improve the targeting of the Poverty Family Benefit to protect the most vulnerable and to reduce the costs to the budget, and to improve the accessibility and efficiency of social assistance. In support of these goals, PADCO has undertaken activities in six areas:

- Improve targeting,
- Increase citizen information and understanding of the role and eligibility for the poverty benefit,
- Improve training,
- Improve information systems,
- Establish Integrated Social Service Centers,
- Improve collection of data about social and health conditions of population.

Increase governmental capacity to plan, finance, monitor, and administer social insurance and social assistance programs

Through all of the efforts to assist the GOAM to establish, reform or improve specific programs and activities, STP has an overall objective of improving GOAM capacity to plan for, monitor, evaluate, and administer social insurance and social assistance programs in general.

In addition to these four reform objectives, through assistance designed to improve programs that directly benefit the most vulnerable, including pensions and the Poverty Family Benefit, STP also helps the GOAM provide urgently needed services.

3. Achievements and Results

State pension system

- **Legal and regulatory framework**

PADCO advisors and lawyers have worked with the staff of the Ministry of Social Security (MOSS) and with lawyers and deputies in the National Assembly to help draft a state **pension reform law**. The draft law was presented to the Government in December 2001 and was submitted to the legislature in January 2002. PADCO lawyers and MOSS staff conducted seminars, roundtables and meetings with individual legislators to explain and generate support for the draft law. The Parliament passed the first reading of the draft pension reform law in June 2002 by a vote of 96-0.

The pension reform law changes the state pension system in several important ways:

- Changes benefit formula to make benefits related to earnings and raises benefits for existing and future retirees;
- Requires creation of a system of personal records of the wages and salary histories of each worker, making it possible to link future benefits to contributions for each worker;
- Separates social assistance from social insurance, moving the payment of benefits to those with little or no work history (social pensions) to the state budget;
- Indexes pensions after retirement to the cost-of-living index;
- Freezes the male retirement eligibility age at 63 and raises the female retirement age to 63;
- Reduces contributions for lowest paid workers and raises them for higher paid workers;
- Requires employers to pay privileged pensions.

A PADCO actuarial consultant has been critical of several features of the pension reform law,¹⁶ but most PADCO and MOSS staff believe that it is a good beginning to reform.

PADCO lawyers and advisors also worked with MOSS staff on a **Personal Number (PN) law**, establishing the legal basis for a system of personal identification numbers. PADCO and MOSS personnel developed brochures explaining the PN and consulted with and explained the proposed law to legislators. The Parliament passed the first reading of the Personal Number Law in May 2002 by a vote of 70-0.

PADCO lawyers and MOSS staff drafted a **Personal Data Privacy Protection Law**, which augments the PN law and provides protection of the confidentiality of personal pension accounts. The Parliament passed the first reading of the Personal Data Privacy Protection Law in June 2002 by a vote of 59-2.

¹⁶ Mitchell Wiener, "Problems with the Draft Pension Law," Armenia Social Transition Program Report No. 48, Yerevan, August 17, 2001. Wiener notes that the draft pension reform law does not address the problem of the high pension dependency rate because it reduces the retirement eligibility age for men relative to the current law and permits many workers to retire at younger ages, and it maintains contributions that are very high relative to benefits for most workers, which will tend to reduce contribution compliance.

- **GOAM institutional capacity to plan, finance and administer the pension system**

PADCO advisors have adapted the World Bank PROST pension model to analyze the Armenian pension system and have prepared **actuarial and financial projections of the pension system** and SIF balances – both in its current law form in 2001 and various reform alternatives. PADCO has provided training in use of the PROST model to MOSS and SIF staff.

USAID and PADCO supported the establishment of the **Nemrout Center for Information and Analysis** of the Ministry of Social Security. PADCO worked with MOSS and the World Bank to design and renovate the center, provided 19 computers to the center and 12 to the computer training center located in the Nemrout Center, and trained computer trainers from the National Statistical Service who in turn are training staff of MOSS and other ministries and social security offices. The Nemrout Center provides the information management support for the PFB and for the PN system.

PADCO supported the establishment of the MOSS **Office of the Actuary**, located in the Nemrout Center, and provided training in actuarial science and modeling to the staff. The Office of the Actuary provides analytical support for MOSS concerning pension reform, as well as analysis of issues concerning the Poverty Family Benefit.

PADCO supported the development of a **Personnel and Training Records** software application to improve administrative efficiency at MOSS and to help MOSS comply with a new Civil Service Law. MOSS is the first GOAM ministry to have such a system. The personnel data system is operated and maintained at the Nemrout Center.

PADCO is supporting the development of a **Complaints and Issues Tracking Application** (CATERS) to track complaints from the public to MOSS. CATERS is to be operated and maintained at the Nemrout Center. This application will establish a database of customer complaints and responses for MOSS.

- **Information management systems**

Development of a **personal number (PN)** system is a key pre-condition to the development of personal social insurance accounts and personified reporting of wages, earnings histories, and social insurance contributions. It will also facilitate the efficient tracking and payment of a range of social and health benefits in the future. Although TACIS and the World Bank have supported the development of a PN system over several years, PADCO's support to the MOSS for the development of the PN has been critical. PADCO support has included development of a legal framework, development of the applications software at the Nemrout Center, support for a pilot implementation of the system, and development of a plan to roll out the system nationally. PADCO worked with MOSS to design a PN system that it is testing in the pilot site of Abovian to determine feasibility, cost and sustainability. PN data are processed and maintained at the Nemrout Center, and Nemrout issues the PN cards. USAID has committed to provide \$1.3 million in computers and related equipment to support the nationwide implementation of PN. PADCO prepared an Information Resource Management (IRM) plan required by the U.S. Office of Management and Budget for the acquisition of the computer equipment.

PADCO is also assisting with information technology (IT) for the **personified system of reporting** of employment, wages, earnings histories, social insurance contributions, benefits application and benefits receipt (PARNAS). The applications software is being designed and developed at the YICRD (Yerevan Institute for Computer Research and Development, also known as the Mergelyan Institute) and will be operated and maintained at the SIF. USAID is providing computer equipment to the SIF to implement the PARNAS system.

PADCO is working with the Mergelyan Institute on the development of computer applications software to maintain the **Civil Status Registry** (OSIRIS). The Civil Status registry tracks seven data elements for each member of the population – birth, death, marriage, divorce, adoption, change of parentage, change of

name. This will be a component of the information flow related to PN. This system will be maintained at Mergelyan for the Ministry of Justice.

PADCO is supporting the development of an information system to **link the SIF central office with regional offices** for the transmission of data on enterprise payments of social insurance contributions and regional office payments of pension benefits.

- **Public education about pension reform**

PADCO has supported MOSS in the development of public education programs to inform the public and GOAM officials and legislators about the need for pension reform and to build political support for reform initiatives. Media events, interviews, press conferences, newspaper articles, briefing papers, brochures, posters and other information have been developed and disseminated to explain why pensions are low, why the retirement eligibility age of women should be changed, and why the pension system should be reformed. Information and public education campaigns have been developed to explain and promote the new PN system. Focus groups have been used to get feedback, test and refine the message. PADCO provided technical support, including computers and related equipment and media subscriptions, to a new public education unit in MOSS.

Nonstate pensions

- **Legal, policy and regulatory framework**

PADCO lawyers and advisors are participating in a working group with staff of MOSS and the Securities Commission to develop a draft law on nonstate pensions and a regulatory framework. The work group includes local advisors from the Capital Markets Development Project supported by USAID under SO 1.3 (being implemented by PriceWaterhouseCoopers).

The Securities Commission of Armenia was established in 2000, the Armenian Stock Exchange opened in 2001, and the Central Depository of Armenia was privatized in 2001 with USAID assistance under SO 1.3, separate from STP. These institutions are vital parts of the financial markets infrastructure that is a necessary pre-condition for the development and efficient functioning of private pensions.

Poverty Family Benefit (PFB) and social services

PADCO has been heavily involved in numerous interrelated activities designed to improve social assistance and social services. The most important social assistance benefit is the PFB. In 1999 the MOSS began using the PAROS data system to target the PFB. PADCO helped MOSS **improve the targeting of** this key program in 2002, when the ministry was directed to reduce total expenditures by 25 percent. Through improved targeting the number of families eligible for the benefit was reduced from 172,000 to 142,000. Average benefit levels were increased for the families found to be eligible under the new targeting system. The actuaries at the new Office of the Actuary in the Nemrout Center developed financial models of the proposed changes in the PFB and produced a report of the effects of the proposed changes. The MOSS and the Ministry of Finance and Economy used these analyses in making policy decisions. PADCO also assisted and guided the MOSS public education department in the development of a **public education campaign** to explain the changes in the PFB. The campaign was credited with the positive public acceptance of the changes.

The PAROS-based poverty targeting system is used by the Ministry of Health (MOH) to determine eligibility for the free Basic Benefits Package (BBP) at MOH polyclinics. The list of eligible families is also made available to NGOs for their use in targeting benefits.

PADCO assisted MOSS in the development of a two-week course for a **training of trainers** program for personnel of the Regional Social Security Centers (RSSCs). One person from each of the 55 RSSCs, plus

five from MOSS and marz (regional) governments have participated in the course. These trainers are now training the 670 personnel of the RSSCs.

PADCO has provided assistance to improve **databases and information flow** between the Regional Social Security Centers and the Nemrout Center, where national data are collected and processed. Twenty RSSCs have had the capability to report directly to Nemrout by email installed and tested.

PADCO has supported the implementation of an **Integrated Social Service Center (ISSC)** pilot to integrate family assistance benefit administration, pensions, disability determination, unemployment compensation and employment programs, and other social services. The pilot ISSC will include a NGO coordination and referral office. The objective is to improve accessibility of social assistance to the most vulnerable, services, targeting, and coordination with NGOs. Training of the management of the ISSC in computer skills and management has been provided. PADCO is supporting the design of an integrated database for the offices of the ISSC. PADCO is assisting MOSS in public education to explain and promote the use of the ISSC.

PADCO has provided support to the National Statistical Service (NSS) to conduct and improve the **Integrated Household Income and Expenditure Survey** to improve the basis for policy analysis, targeting, and monitoring. PADCO provided computers and statistical software to the NSS and conducted training of NSS specialists and interviewers. NSS now conducts training in computer skills and software applications for personnel of MOSS, MOH and SIF at the Nemrout training center. NSS is now conducting the 2002 Integrated Household Survey, interviewing about 350 households each month, with a total annual sample of about 4,000 households.

PADCO has contracted with the NSS to conduct a **survey of public use, knowledge, and perceptions of social and health services**. The survey, with a sample of 1,300 households in five marzes, is used to monitor the success of STP and to present a picture of changes in the well-being of Armenian households. The third survey was conducted in November 2001. Results were reported in March 2002. The survey helps USAID monitor the progress of the STP and also has provided revenue and valuable experience to the NSS.

Increase governmental capacity to plan, finance, monitor, and administer social insurance and social assistance programs

While focused on specific programs and activities, STP efforts have been designed to increase government capacity to plan, monitor, evaluate and administer social insurance and social assistance programs more generally.

Development of **actuarial training programs and establishment of an Office of the Actuary** provides analytical input into the pension reform process, but also provides analytical support to efforts to improve and target the Poverty Family Benefit. The actuaries being trained can also provide analysis needed to develop public and private health insurance, nonstate pensions, disability insurance, life insurance, and other social insurance.

Work on draft laws and regulations is done jointly by PADCO lawyers and advisors working with GOAM lawyers and staff of ministries and regulatory bodies, with the objective that GOAM personnel understand the thinking behind the reform process, take ownership of reform proposals, and develop the capabilities to develop the legal and regulatory basis for future social and health reform.

Training programs emphasize **training of trainers and the creation of ongoing training capabilities** and practices, to make skills acquisition and improvement an integral part of MOSS operations and capabilities.

Databases, information technology, and the analytical capabilities of the **Nemrout Center, the SIF and the Mergelyan Institute** can be applied broadly to ongoing reform efforts.

The skills and experience of the **National Statistical Service** in data processing and statistical analysis gained through the survey of household income and expenditures and the STP survey of public use, knowledge, and perceptions of social and health services can be applied broadly to the reform process and can be used to train personnel of other GOAM agencies.

Meet the immediate social and health care needs of the most vulnerable

Most STP activities and programs in the social sector that are designed to provide urgently needed services are carried out by NGOs, and are discussed in Section III C of this report. Some reforms address immediate social needs of the most vulnerable. The improved targeting of the Poverty Family Benefit and increase in the benefit level for families determined to be eligible for the benefit under the revised target criteria had an immediate effect of increasing the incomes of those families judged to be the most vulnerable. The modest reduction in poverty indicated in the 2001 NSS household survey of income and expenditures, and particularly the reduction in the proportion of the population in the “very poor” category, has been attributed in part to the general improvements in targeting of social assistance that have occurred since 1999.

4. Constraints

A number of constraints have limited the achievements and progress in improving social insurance and social assistance or may do so in the future.

Low productive capacity of economy, low incomes, and poor collection compliance constrain ability to pay adequate pensions

Some of the reforms included in the draft pension reform law that Parliament passed the first reading are designed to increase pensions modestly. These include moving payment of social pensions to the state budget and making employers responsible for privileged pensions.¹⁷ However, as long as wages and incomes remain low, it will not be possible for Armenia to pay adequate pensions.

The most serious structural problem of the pension system is the very high system dependency rate – the ratio of benefit recipients to contributors. Currently, about 502,000 pensions are paid. Contributions are paid for about 420,000 employees, yielding a system dependency ratio of 1.2 benefit recipients per contributor. The dependency ratio is very high because of two major factors: the retirement age is low by international standards, and the contribution collection compliance rate is very low. These factors are not adequately addressed by the current reform proposals. Under the current pension law the retirement

¹⁷ Social pensions are minimal pensions that are paid to elderly or disabled persons who do not have sufficient employment history to qualify for a workers pension. In this sense, social pensions are welfare benefits rather than social insurance benefits.

Privileged pensions are more favorable retirement pensions granted to classes of workers who have been designated in the pension law to have worked in especially difficult or dangerous occupations or in especially meritorious occupations or have performed services to the country or experienced particular hardships. Under some privileged pensions workers can retire with full pension at earlier ages than the standard retirement age. For example, for workers in occupations in “List #1” in 2002 men could retire at age 53 ½ and women at age 48 ½; in “List #2” men could retire at 58 ½ and women at 53 ½. Mothers of four or more children, dwarfs, air crew members, educators, some performing artists, prosecutors, judges, people who suffered political repression, and other categories have privileges including eligibility for early retirement or supplements to the standard pension. These privileges, inherited from the Soviet pension system, are arbitrary, reduce the average retirement age, and add significantly to the costs of the system.

eligibility age for men is scheduled to increase to 65. The reform proposal freezes the retirement age for men at its current level of 63. It does raise the retirement age for women to 63. Contribution compliance is low because the pension system pays very low benefits relative to contributions – even under the reform proposal the rate of return on pension contributions for almost all workers will continue to be negative. Therefore, most workers will not have an incentive to pay contributions voluntarily, even after they have personal accounts and the benefit is linked to contributions paid. While the introduction of personal accounts and the linkage of benefit amount to contributions are expected to increase contributions, if benefits remain low relative to contributions, most workers will not have an incentive to pay contributions. The World Bank has estimated that 30 percent of potential contributions are not collected.¹⁸ It is vital that Armenia reduce the number of pensioners and increase the number of contributors if adequate pensions are to be paid.

Collection capacity of SIF is inadequate

The SIF audits most employers only about once every three years. Court costs restrict the number of cases for which the SIF seeks legal enforcement. The implementation of the PN system may improve the situation. However, this will take several years. Tax system automation and assistance provided under USAID Strategic Objective 1.3, IR 2 should be extended to the SIF. USAID and the World Bank should discuss with the GOAM and the SIF consolidating collection of social insurance contributions with other tax collection.

Clarification and commitment of resources to implement PN system nationally

USAID has committed to provide the computers and associated hardware. The Prime Minister has promised that the 2003 budget would include funds for PN implementation. After the PN pilot is completed in October 2002, STP will assess whether the budget promised by the GOAM will be sufficient to fund the national implementation of PN. One-time start-up operating expenses are estimated to be \$500,000-700,000. It is not clear who will take responsibility for these start-up costs. After the pilot is analyzed, STP should develop a comprehensive national implementation plan, including detailed cost estimates. USAID, the World Bank, and the GOAM should then jointly determine how the implementation costs will be funded. USAID and the World Bank should develop conditionalities to assure adequate ongoing GOAM budgetary support for operation and maintenance of the PN.

Resources – human and financial – to sustain information systems

STP is supporting the design and development of many information systems. It is uncertain whether Armenia will mobilize the resources to maintain these systems, particularly in the regions away from the capital where the information technology infrastructure is inadequate – ranging from telecommunications to persons skilled in computer hardware maintenance. Armenia has the basic human resource endowment – a well-educated population and a still adequate education system. Large numbers of skilled workers are unemployed, and many skilled Armenians are now working in other former Soviet republics. STP should begin training now in the required software systems and in computer and telecommunications hardware maintenance skills, both in Yerevan and in regions outside the capital. The PN national implementation plan should include a system of hardware maintenance contracts tendered in regional centers that cover the entire country. Development of computer hardware repair and maintenance enterprises should be promoted by USAID under SO 1.3: *Growth of a competitive private sector*, IR 3, through micro-enterprise loan programs and provision of capital to small and medium enterprises (SMEs) in information technology. (These could ultimately develop into a network of computer sales and service enterprises.) Linkage of the training provided under STP, the potential revenue base that could be provided by hardware maintenance contracts, and financial and technical assistance to enterprises provided under SO 1.3 could be mutually beneficial to foster the development of computer sales and service enterprises. The

¹⁸ A PADCO pension advisor estimated that half the total workforce evades contributions. Mitchell Wiener, “Valuation Report on Proposed Pension Reform,” Armenia Social Transition Program Report No. 37, Yerevan, June 14, 2001. The Vice President of the SIF estimated that underpayment was about 10-15 percent. Personal interview, July 30, 2002.

information systems being developed under the STP, including the PN, should be included in the national Information and Communications Technology (ICT) Master Strategy, which has been developed with USAID assistance under SO 1.3.

Inadequate financial market and insurance market to support nonstate pensions

Development of viable nonstate pensions requires a range of financial market and insurance market institutions, including access to a diversity of sound financial investments, adequate and transparent regulatory institutions, and insurance products such as life insurance and annuities. These currently do not exist in Armenia. USAID is supporting the development of many of these institutions, especially under SO 1.3, but time will be required for an adequate legal and regulatory basis to be established and for the knowledge, skills, experience and standards to be developed. With USAID assistance, under SO 1.3, the Securities Commission of Armenia was established in 2000, and the Armenian Stock Exchange was established as a self-regulated organization in 2001. Representatives of the Securities Commission, along with USAID consultants working on the SO 1.3 Capital Markets Project, work with STP experts in the design of a proposed law on nonstate pensions. The continued close linkage of STP assistance to the development of nonstate pensions and USAID assistance to capital markets under SO 1.3 will be mutually beneficial.

Limited opportunities and requirements for actuaries

PADCO has supported the development of an actuarial sciences program at Yerevan State University and the establishment of an Office of the Actuary at Nemrout Center. Seven students are expected to complete the Masters Degree program in spring 2003, and four persons have been hired in the Office of the Actuary. There is currently insufficient work for the prospective actuaries and actuarial students for them to acquire the on-the-job-training required and for the development of professional standards and practices. The integrated STP approach to activities in the social sector and the health sector may broaden the opportunities and needs for actuaries and may potentially help alleviate this constraint over time. STP is promoting a broad range of reforms in social insurance, health insurance, health care finance, and social assistance, which will increase opportunities and may partially alleviate this constraint. Greater coordination between the STP and the programs to strengthen insurance and financial markets being implemented under the USAID Mission's Strategic Objective 1.3 related to IR 3, Access to Financial Capital, might also increase the opportunities and utilization of actuaries.

5. Prospects for Sustainability of Reforms and Reform Process

Momentum and capacity to reform existing state pension system

The personnel of MOSS, including the Minister of Social Security and all the senior staff interviewed by the evaluation team, appear to be capable and highly committed to the reform program. The government officials of Lori marz also appear to be capable and committed to the reform. The commitment of the GOAM in general is more uncertain. MOSS does not have adequate budgetary or staff resources to support and sustain the implementation of reforms. The social sector appears to be a low priority for the GOAM. Perhaps through World Bank conditionalities, the GOAM should be urged to maintain and increase budgetary support for reform and capacity building in the social and health sectors. Budgetary support for those sectors should grow at least as fast as GDP and tax revenue.

Information systems

GOAM is unlikely to commit sufficient resources for national implementation and maintenance of the many information systems that are being developed with PADCO support in the short-term and probably intermediate-term future (3-5 years). USAID together with the World Bank and other donors should be prepared to guarantee provision of funds necessary for national implementation of the PM and other information systems. It is expected that the PN will lead to an increase in contribution collections that is sufficient to convince the GOAM to maintain the system. If the PN is a component of a reformed pension system establishing individual accounts that are used to determine pension benefits, it is likely that popular pressure will assure that the system is maintained.

Operation of social insurance and assistance system

PADCO is supporting and promoting improvements in many aspects of the social insurance/assistance systems, many of which are likely to require additional staff and operations costs, including upgraded and integrated regional and local offices. International donors, including USAID, the World Bank and others, have paid most of the costs of these improvements – e.g., design and development of new information systems, training programs, public education programs, Nemrout Center, PN pilot, ISSC pilot.¹⁹ It is not clear that the GOAM will devote the resources to cover the higher level of operating costs that may be required. If these programs prove to be beneficial, conditionalities should be considered to encourage the GOAM to maintain sufficient support. Supporting the new systems and programs is dependent on continuing growth of the Armenian economy.

6. Gaps

Several important areas of social sector reform and development have not been included or have not been adequate during the first two years of the STP.

Employment and labor market

The STP has included virtually no programs addressing the labor market and unemployment. This is particularly puzzling, considering that employment was identified as “the mission’s highest priority – and as a result, a higher order ‘strategic goal’ ” in the USAID/Armenia Strategic Plan for FY1999-2003.²⁰ The MOSS’s Republican Labor and Employment Service conducts both active (job training and retraining and job placement) and passive (unemployment compensation) labor market policies. The Republican Labor and Employment Service (RLES) has received significant technical assistance from the EU TACIS and from the Swedish SIDA, but these programs have ended. The RLES will be unable to continue making needed improvements without additional technical assistance, and it would welcome USAID support.²¹ In many areas employment and unemployment programs could logically be joined with other STP activities in the social sector, including the following:

- Monitoring and evaluation of employment programs and unemployment benefits, improved targeting, and interaction with other elements of social insurance and social assistance, especially the Poverty Family Benefit. This will occur naturally at the local level if the ISSC concept is implemented in all regions, since the Labor and Employment Office is included in the ISSC.
- Linkages of employment and unemployment databases and other social insurance/assistance databases. With support of TACIS, the Labor and Employment Service developed an information system to collect and process data on the registered unemployed and convey the data from the regions to the central office (SEVAN). Only 22 of the 51 regional RLES centers are included in the system. This system should be linked to other information systems on social benefits being supported by STP.
- Integration of the system of unemployment benefits with pensions and social assistance. Unemployment benefits, to the degree they are paid at all, are paid from the SIF, as are pensions. This commingling of social insurance contributions is problematic. Whether commingled or separate, unemployment benefits and pensions impose competing demands on the same wage base and must be considered jointly. Both unemployment benefits and pensions, as well as the Poverty Family Benefit, provide support to vulnerable families.

Labor market and employment programs would seem to be particularly appropriate for the STP strategy, since they combine both assistance to vulnerable families, in the form of short-term unemployment

¹⁹ The MOSS and the Marzpet of Lori have committed to pay more than half the costs of refurbishment of the ISSC facility.

²⁰ USAID/Armenia Strategic Plan FY1999-FY2003, Yerevan, March 1999, p. 14.

²¹ Interview with Gagik Bleyan, Director of the Labor and Employment Service of the Republic of Armenia, August 5, 2002.

benefits, and development activities, in the form of retraining, job information and placement, and employment creation activities.

Social services and social workers

Trained and motivated social workers can be a valuable element in the provision of social benefits. Social workers can bring together all of the resources that the government has to assist the needy, including social assistance, social services, employment assistance and health care. They can improve targeting of benefits. The GOAM has relatively few trained professional social workers. STP has provided only modest efforts in this area. PADCO has supported improvement in the approach to household visits by RSSC staff by developing, in collaboration with MOSS and Yerevan State University, a home visits manual that can serve for instruction and training, which focuses on auditing benefit eligibility and social inspection.

Coordination and involvement of Ministry of Finance and Economy (MFE)

It appears that personnel of the MFE are involved in STP only to a very limited extent. MFE has a key role in reform of the state pension and has important responsibilities in the development and supervision of institutions required for nonstate pensions. MFE has responsibility for the state budget. To the degree that assistance to the social and health sectors from international donors is offset in part by state budget cuts, greater coordination with the MFE could greatly enhance STP efforts.

Training for social policy implementation and management of government leaders at the regional (marz) and local government levels

PADCO conducts numerous training programs for personnel at the ministry level and local and regional office levels. One area where additional training may be effective would focus on the political leadership at the regional and local level – in particular, the marzpet and senior marz social and health officials. It may be useful to promote greater interaction among marz government officials regarding social assistance, social services and health care, and comparison of experiences among marzes. This is vital if STP is to leverage the experience acquired through pilot programs concentrated in five marzes. Increased training at the marz government level would also promote the STP objectives of clarifying the roles of central and local government in the provision of social and health services and supporting the stated GOAM goal of decentralizing responsibilities to the local level.

Contracting with nongovernment organizations, including for-profit firms

A strength of the PADCO approach taken during its first two years is its heavy reliance on local capabilities – from contracting with the NSS to conduct the ASTP survey of use, knowledge and perceptions of social services, to heavy use of the Mergelyan Institute for design/development of information technology projects, to use of local contractors for facilities renovation. PADCO should also pursue opportunities to contract out, to the degree possible, the design and delivery of social services and benefits, to for-profit businesses as well as NGOs. This may require the establishment of a legal framework for increased reliance on private sector organizations to perform tasks that have traditionally been considered to be the responsibility of public entities.

Support for development of insurance products and financial markets

An active insurance industry, as well as well-developed financial markets, is a pre-condition for the development of nonstate pensions and other products to permit individuals to mitigate income and health risks, without relying exclusively on the government. While STP is developing a legal framework for nonstate pensions, it is doing little to expand and enhance financial and insurance products. Expansion of the insurance sector is vital if the actuarial capabilities being supported by STP are to be fully utilized. STP should coordinate with USAID contractors and advisors working on SO 1.3: *Growth of a competitive private sector*, to assure that the types of products and institutions required for increased private provision of social insurance are being developed.

Income distribution

While a large share of the population of Armenia remains poor, a segment of the population is emerging that has significant income. The growth of income and wages that has occurred since 1993 has not been evenly distributed. Armenia is reported to have the most unequal income distribution of the former Soviet Union or Eastern Europe countries.²² Looking forward, as the economy continues to grow, USAID and STP should promote measures and raise the attention of GOAM policy-makers to encourage and require Armenians with higher incomes to share in the responsibility of caring for and assisting the most vulnerable. USAID should continue to support the Poverty Reduction Strategy Paper exercise and its explicit consideration of income distribution issues. USAID assistance to improve contribution collection by the SIF, to improve tax collection under SO 1.3, IR 2, and to reduce corruption under SO 1.3, IR 2 and SO 2.1: *More transparent, accountable, and democratic governance*, may also serve to promote a more equitable distribution of income.

B. Health Sector Reform

1. Background

Armenia's health care system is an outgrowth of the Soviet period. During this period almost all health care services were provided through the government. In theory, high quality services were provided to everyone on an equal basis at no charge. The system did achieve considerable results; care was provided to almost everyone, although that care was often of dubious quality. Access to the best facilities and physicians was rationed, with the best services going to government and communist party officials. Efficiency was not a high priority. The system relied heavily on specialists and sub-specialists with relatively few generalists. Thus, health experts often describe the Soviet (and Armenian) system as having inverted the traditional health pyramid. Instead of having many generalists with a smaller number of specialists who deal with the small number of unusual or very complex cases, the Armenian system has a small number of generalists who essentially served a referral function, passing patients on to the system's numerous specialists for treatment. Other problems included antiquated diagnostic and treatment protocols, poor record keeping, and little clinical training.

The collapse of the Soviet Union and Armenia's other economic problems severely reduced the resources available to finance this system. The MOH has been unable to provide medicines, equipment and maintenance. Salaries have often been delayed or simply not paid. The quality of care has declined, as has the public's confidence in and utilization of the system. This has contributed to enormous excess capacity in the system. In the small sample of clinics visited by the assessment team, there were fewer than two patients per day per staff member.

The Ministry of Health (MOH) recognizes that the old Soviet vision of a broad range of free, highly specialized care for everyone, never actually achieved, has no relevance in today's Armenia. The MOH has taken a number of steps to address the deterioration in health care services. It has, for example, defined a Basic Benefits Package that identifies those health care services that should be available to all Armenians. Fees have been introduced, allowing health facilities to generate income to supplement the dwindling MOH resources. In theory, fees are not charged to the very poor who qualify for the Poverty Family Benefit, and some services (e.g., prenatal care) are supposed to be free for everyone. However, substantial anecdotal evidence suggests that MOH providers often charge for services that are supposed to be free, and they charge more than authorized levels for paid services. Surveys of health seeking behavior show that the decline in utilization reflects, in part, the fact that families find the fees unaffordable.

There is a realization (at least among senior MOH personnel) that the old Soviet system had serious flaws and that, even if resources were adequate, the system of health care financing and delivery must be fundamentally changed. With technical assistance from the World Bank, USAID/Armenia and others, the

²² Republic of Armenia, *Interim Poverty Reduction Strategy Paper*, Yerevan, March 2001.

MOH is attempting to restructure its health system, including the financing of health care, focusing on the building of an efficient primary health care (PHC) system.

USAID/Armenia's STP health program incorporates several activities.²³ These include:

- **PADCO.** The largest health component in the Mission's portfolio is a contract with PADCO, which includes several subcontractors. The major health subcontractor is **Abt Associates**. Other subcontractors are AIHA, AMEG, Counterpart and QED. The PADCO contract focuses on (1) increasing access to and quality of PHC in selected regions through developing a family practice system; (2) legislative and policy reforms which support an increased focus on community-based PHC; (3) creating an effective health management information system; (4) reforming health finance; (5) helping Armenians become better informed about personal health care rights and obligations; and (6) increasing the coverage of Armenia's most vulnerable families by basic health benefit programs. (To differentiate its activities from the rest of the STP program PADCO refers to its contract activities as the "Armenia Social Transition Program," or ASTP.²⁴)
- **AIHA.** Supported through a Mission "buy-in" to a Caucasus regional cooperative agreement in 1998, AIHA has established four active health partnerships. These partnerships utilize U.S. health professionals who volunteer their time to assist intermittently to strengthen Armenian health care facilities. The focus of three of AIHA's active partnerships, established in August 1999, is on strengthening PHC. The focus of the fourth partnership, established in February 2000, is women's health. These activities pre-dated the development and implementation of the STP but are consistent with it. They are separate from and in addition to AIHA's role as a PADCO subcontractor.
- **PRIME II.** This activity is financed through a Mission buy-in to a USAID/Washington global contract. PRIME II's focus in Armenia is on maternal and newborn health, including antenatal, postpartum, intrapartum and newborn care in Yerevan and in Lori Marz. PRIME II partners are the MOH, the Republican Center for Perinatology, Gynecology and Obstetrics, and the Lori Marz government. PRIME has identified the *feldshers* (rural health providers) as the group with an untapped potential to impact maternal and newborn health positively. PRIME II has as an objective to make the *feldshers* effective providers of PHC by improving the staff's technical competence with the appropriate training and supportive supervision. PRIME II is also working with the PADCO team to develop those parts of the family medicine (FM) curriculum dealing with maternal and infant care.
- **MACRO/DHS.** This activity is implemented through a buy-in to the MACRO contract for Demographic Health Surveys (DHS). The primary objective of a DHS is to better understand the health problems of women of reproductive age and the health of their children. MACRO completed the DHS and published its report in December 2001.
- **Carelift.** This activity is implemented through a buy-in to a USAID regional program. Carelift provides medical equipment, disposable supplies, pharmaceuticals and furniture to selected Armenian health care facilities. Most of the commodities supplied are donated by U.S. health care providers.

²³ The activity implemented by MACRO is completed. All other activities in this list remain active.

²⁴ The use of ASTP is a PADCO convention and not one that the USAID Mission typically uses. Nevertheless, because many of the activities carried out under the PADCO contract in the health sector have been implemented by Abt Associates and other subcontractors, the assessment team feels that it is appropriate to utilize the term ASTP rather than PADCO in describing those activities.

- **UMCOR and CRS.** Through Mission-based cooperative agreements, these institutions provide health and nutrition activities. (A description and assessment of these activities is provided in Section III.C below.)

This assessment will focus largely on the programs carried out under the PADCO contract and the NGO cooperative agreements – programs that were undertaken specifically to support STP. Mission support for AIHA, PRIME II and MACRO has been incorporated within the broad STP framework, but these programs appear to have been undertaken more in response to Congressional earmarks and exhortations and to other factors than to a conscious effort to program resources to achieve STP objectives. The AIHA partnership cooperative agreement pre-dates the STP.

This being said, these programs can claim a considerable degree of success in their own right (i.e., in terms of achieving their own specific objectives) and to have contributed to some extent to the core STP program.

- MACRO has completed its work on the Armenia DHS, and its work appears to reflect the high standards for which the DHS is recognized. Reliable data are key to the development of a more efficient system with better targeted services, and the DHS is a step in that direction. However, it is not clear that the DHS is as yet being utilized to support these larger health sector (and STP) objectives or that the DHS exercise will have a major long-term impact on Armenia's ability to collect and analyze such data.²⁵
- In comparison to the PADCO program, AIHA partnerships take a more bottom-up approach to reform. AIHA works with local facilities or regional authorities to improve services, equipment and facilities. AIHA partnerships contribute to STP intermediate results IR 3.4.3.1 and IR 3.4.3.2, improve quality and increase access to primary health care services. The observations of this team (and of the health sector assessment team) suggest that AIHA partnerships are highly appreciated by the Armenian facilities involved, and these facilities appear to have made substantial progress in their ability to offer quality health care services within the catchment areas.

Ideally, AIHA partnerships would become models for similar institutions, spreading the benefits throughout the system. This is an explicit goal of the partnerships. However, it was not evident to the assessment team that there is an effective mechanism to ensure that lessons learned are shared with other parts of the health system. Although AIHA carries out some activities for a broader range of Armenian health institutions and facilities, the size and nature of these AIHA activities do not appear adequate to convert individual AIHA interventions into an effective bottom-up effort to reform the health care system.

Efforts to train medical staff in family medicine do complement PADCO's health sector reform efforts, although the two efforts follow quite different strategies and there is little sharing of information or lessons learned.²⁶

- PRIME II's work, which is still at an early stage, should strengthen the quality of PHC services related to maternal and child health.²⁷ Much of the PRIME program is designed to train Armenian practitioners to deliver better maternal and child health services. These activities are complementary to but not integral to ASTP efforts to reform the way health care services are delivered and financed. However, some of its activities, particularly its efforts to work with

²⁵ The Minister of Health expressed reservations about using the DHS for policy. Interview, July, 24, 2002. See also the Health Sector Assessment, page 45.

²⁶ For a fuller discussion of AIHA's various activities in Armenia, see the Health Sector Assessment, pp. 51-53.

²⁷ PRIME II replaced earlier programs being implemented by Johns Hopkins University and the PVO/NGO Networks. The PRIME II workplan was accepted by the USAID Mission in February 2002 and work began in April 2002.

PADCO in the development of programs to train family practitioners, will contribute to the achievement of STP goals.²⁸

2. Goals, Activities and Results

Armenia's health care reform is intended to improve the quality of and access to care for all citizens. To achieve this, Armenia will need to fundamentally restructure the health care system, eliminating excess capacity and redirecting resources to create an effective and efficient primary health care system.

PADCO's efforts are directed toward assisting the MOH in four key areas, identified as "pillars:"

- Strengthening governmental capacity to implement health care reforms
- Restructuring health care financing
- Developing family medicine
- Rationalizing the use of existing health resources

PADCO has identified eleven areas of activity through which it pursues these goals. These are summarized in the following paragraphs.

• Health Care Financing

The objective in this area is to help the MOH restructure its financial operations, adopt modern cost accounting and reporting systems, and develop efficient methods to finance primary health care. The program seeks to develop a Basic Benefits Package (BBP), adequately financed, efficiently managed and evaluated, with funds flowing through a health care delivery system that includes financial incentives for efficient care delivery.

PADCO's achievements to date include development of recommendations for mandatory national health insurance, assistance to MOH in drafting a law on mandatory national health insurance, which has been submitted to parliament, development of a work plan for introducing administrative reforms in health care finance and budgeting systems, and development and pilot testing of an automated financial reporting system (MIDAS). PADCO advisors are also working with counterparts on the development of a scheme for capitated payments to family group practices (FGPs), preparation of the national health budget for 2003, improvements in the definition and administration of the BBP, and methods to address under-the-table payments.

Health care financing reform is just beginning. Two years is not an adequate period to address the many complex issues that must be tackled. The contractor's current effort to assist the MOH with the 2003 budget may offer an opportunity to reallocate resources and introduce improved budgeting techniques. PADCO's willingness and ability to take on this assignment, not initially contemplated in its scope of work, attests to some management flexibility in the program design to respond to opportunities.

The unresolved question of capitated rates for FGPs needs to be dealt with soon, as the first FGPs are expected to begin operations soon. PADCO health advisors indicate that the capitated rate to sustain FGPs may need to be equivalent to six times higher than payments currently going to polyclinics. It is not clear how this issue will be resolved.

• Licensing and Accreditation

The ASTP objective is to help the MOH improve the licensing of public and private PHC providers, including both individuals and institutions. Licensing and accreditation are important and sensitive issues, as they affect the number of medical specialties and the standards (or the lack thereof) of facilities and practitioners.

²⁸ For a fuller discussion of PRIME's activities in Armenia, see the Health Sector Assessment, pp. 47-49.

ASTP has provided technical assistance and organized workshops to introduce new concepts and methods with respect to licensing and accreditation and to discuss how these might be applied in Armenia. ASTP's recommendations for action were incorporated into its March 2002 Report No. 62: *Recommendations for a Strategy to Implement Licensing and Accreditation in Armenia*. A working group has been formed within the MOH to consider these recommendations and to move the process forward. However, both MOH and ASTP personnel indicated to the assessment team that little progress is being made.

- **Quality Assurance (QA)**

The objective is to increase the percentage of facilities complying with quality standards, as measured by a monitoring system. Achievement of this objective is thus related to the development of licensing and accreditation.

ASTP has completed reports identifying QA clinical indicators that could be used in licensing facilities and practitioners and suggesting changes in the systems for setting standards and for monitoring quality of services. The Health Information System (HIS) plan incorporated proposals to utilize International Classification of Diseases - 10th Edition (ICD 10) standards as norms in Armenia, but implementation of that plan has been delayed. The ASTP team is currently working with MOH and State Health Agency (SHA) counterparts on a health care standards manual. Work in this area has been closely coordinated with other donor organizations, particularly with a Dutch firm, TNO, and with the World Bank.

ASTP is also working on QA at its pilot sites. The ASTP team has organized numerous QA seminars and is working with the staffs of these facilities to improve clinical practice guidelines and the monitoring of practices. The Polyclinic 17 staff has organized a Committee on Quality Assurance, and ASTP reports that it has put in place the capacity to monitor and measure the impact of changes in the quality of care in the Vanadzor pilots. These QA and monitoring systems are expected to be incorporated into the reimbursement scheme for FGPs.

- **Pharmaceutical Monitoring**

The objective of this assistance is to establish a system for monitoring and managing supplies of essential pharmaceuticals. Work on this component remains in the planning stage.

- **Health Information Systems**

The objective (to be reached after four years) is to establish a health information reporting system that integrates the activities of all health care providers. Its goal is to provide complete reporting of cost, epidemiological and caseload data. Current reporting systems are burdensome and ineffective, sometimes reinforcing the antiquated system of over-specialization. ASTP points out that, as part of an effort to promote transparent accounting procedures and to improve national tracking of needed health indicators, Armenia needs an information system at the provider level that tracks all patient encounters and procedures with standardized, internationally accepted nomenclature.

ASTP worked with counterparts, TNO and the World Bank (WB), to develop a plan that would create an integrated system capable of meeting the needs of the MOH, the State Health Agency (SHA), the National Institute of Health (NIH), and other relevant agencies. The plan was accepted by the WB's Project Implementation Unit (PIU), which proceeded with the procurement of the needed computer equipment. Some delays in procurement, however, have been encountered. ASTP is currently testing the computerized reporting system in three hospitals.

ASTP is moving ahead with other information systems on a pilot basis in Lori Marz. Accurate data on the catchment areas for Polyclinics #1 and #4 are important for the testing of the FGPs. ASTP is also developing relational databases in Lori, building on a personnel database, and financial, facilities and equipment databases.

Cooperation between ASTP and the SHA has been fruitful. ASTP assisted SHA in recovering its database, after it had suffered serious damage. SHA now has the capability of operating the database system.

The Medical Information Data Analysis System (MIDAS), developed with ASTP's assistance, provides the SHA with the capacity to collect, monitor and analyze information in a timely manner. Expenses incurred when diagnosing and treating patients covered by the state order or Basic Benefits Package (BBP) are reported for individual patients by health facilities on a monthly basis. SHA's old system provided aggregate information for groups of patients. SHA currently collects over fifty different reports. Consolidating and computerizing relevant forms is an ongoing process. As a result of this positive outcome, further collaboration was planned, including PADCO's assistance to SHA to review the BBP for vulnerable groups, ensuring that only essential services are included in the benefits package. This assistance has helped the agency to streamline its budget and closely monitor the cost of providing services under the BBP.

The SHA is negotiating at present with the staff managing SanEpid, the epidemiological data bank, to integrate these two systems. This integration would be mutually beneficial for the two agencies, because they would be able to share information needed to enhance both systems. SHA is also planning to negotiate with the MOH to integrate the HIS with MIDAS. These three systems would benefit greatly from sharing the information generated by each one of them. Unfortunately, the MOH still does not have a computer center for the development of the HIS. This computer center is to be provided by the WB. Operating the HIS will require considerable capacity building.

The SHA continues pilot testing its computerized reporting system (MIDAS) at two hospitals in Yerevan – Erebuni and the Ophthalmology Hospital – and at the Psychiatric Hospital in Sevan. ASTP continues to assist SHA in this endeavor.

Work on the information systems seems to be progressing well. If pilot tests prove successful, ASTP will assist in rolling-out these systems to other facilities.

- **Analysis of Existing Facilities**

This element of the ASTP is intended to assess the capabilities and needs of several sites so that they could be converted into pilots for PHC reform efforts. ASTP's analysis found that facilities needed a variety of changes, including renovations, the installation of heating, the addition of PHC-related equipment, etc. The completion of this work has proven to be quite time-consuming and burdensome.

- **Optimization**

“Rationalization” of facilities or “optimization” refers to the reduction of the redundant capacity of the medical facilities in Armenia. While the population in Armenia is approximately three million people, the capacity of the medical facilities, including staff, is large enough to serve a population two or three times that size.

It is obviously important that facilities and personnel not be reduced in an arbitrary manner, but rather in a manner consistent with other sector goals (e.g., increasing the focus on PHC). In this sense, everything that ASTP is doing is complementary to (perhaps even essential to) the optimization process.²⁹

²⁹ A key USAID staff member suggested to the assessment team that everything that ASTP is doing is not only complementary to the optimization process but an integral part of it. While this viewpoint is reasonable, the team found that the term is commonly used more narrowly in Armenia to refer to measures specifically undertaken to reduce excess capacity. In this report, the team utilizes this narrow definition.

The World Bank has provided technical assistance to the MOH on optimization planning since the beginning of the 1990s. When the STP was initiated, initial optimization plans and implementation were already under way, with various facilities already reconfigured by the MOH with assistance from TNO. ASTP collaborates closely with the WB on technical assistance and contributes to the development of conditionality for WB Structural Adjustment Credits.

The MOH completed a first round of optimization that closed or combined a number of facilities. However, the planning and analysis that proceeded that exercise was limited, and the reductions were not substantial. As there were few employees released through that process, it had few of the social and political repercussions that could result as this needed process continues.

Eliminating excess capacity in Armenia's health sector is a process that will take many years to achieve. Although ASTP has not been a key actor in the optimization effort to date, it has provided useful inputs to that process. Currently its work in this area focuses on the development in Lori Marz of databases on facilities, resources and utilization patterns that could form the basis for subsequent rounds of facility and staff reductions in that region.³⁰ ASTP has also developed a "how to" guide for carrying out assessments of a facility's financial resources. That guide will be distributed nationwide, and additional "how to" guides will be developed to describe how to deal with the legal, administrative, managerial and personnel aspects of facility closure or merger.

- **Health Legislation**

The objective of this component is to provide recommendations to the MOH for a legislative and regulatory framework for the provision of PHC. As noted above, ASTP lawyers and other specialists collaborated with the MOH on the development of draft legislation for mandatory health insurance. A more urgent legal issue relates to permitting polyclinic-based autonomous FGPs. The MOH appears to be convinced that it has the authority to proceed and plans to do so. ASTP plans to work with the MOH on draft legislation that facilitates the creation of independent FGPs.

- **Health Care Pilot Programs**

Health care pilots form a key part of the ASTP program. They test many of the concepts and programs that are being developed. The pilot sites include Polyclinic #17 in Yerevan and Polyclinics #1 and #4 in Vanadzor. The staff in each of these facilities have participated in a variety of ASTP-organized training seminars and workshops. Much of the training provided is intended as a precursor to the development of FGPs at these facilities. Polyclinic #17 has been the site of 20 seminars on clinical management issues and family medicine. Six workshops have focused on improving clinical skills. In Vanadzor, 30-40 physicians and 30-40-nurses are participating in weekly clinical training on a variety of topics.

- **Family Medicine: Curriculum and Training**

The objective of this activity is to train physicians who will provide services as family practitioners, many of whom might choose to work in FGPs. Developing this training program is complicated, as the concept of family medicine is not well understood or appreciated and is, in many ways, contrary to the traditional organization of medical practice in Armenia.

Because of delays in the implementation of the ASTP health reform program experienced during the first year of the project, there has been considerable pressure on ASTP to get this training established and to form FGPs. ASTP has responded in both areas. The training of family practitioners in Vanadzor is now underway in Vanadzor Polyclinics #1 and #4. The physicians currently being trained are drawn from those clinics, and most of them are expected to join family group practices that will be organized in space

³⁰ In a meeting with the assessment team, a senior MOH official questioned whether this ASTP work in Lori was consistent with the Ministry's national optimization planning. That larger effort is assisted by a grant from the Japanese Government.

set aside in those same clinics. The best of the graduates are expected to become the trainers of other physicians who will become family practitioners.

ASTP is also assisting a curriculum working group composed of representatives of the MOH, NIH, State Medical University (SMU) and BMC. This working group is developing a set of Clinical Instruction Guidelines (CIGs) built on the WB's Clinical Practice Guidelines. These guidelines will serve as practical patient-based teaching tools for FM faculty at all four institutions. PRIME II is collaborating with this group in developing a Reproductive Health curriculum for the MOH.

Although training in family medicine is underway, to date the curriculum is only partially developed. The technical areas in which training is taking place do not appear to be those for which the curriculum has been prepared. Two U.S. physicians who recently spent a month teaching in the Vanadzor program reported that the topics that they addressed in the training were chosen by the medical director of the facility or by the trainees and often had little relevance to clinical practice. Other weaknesses identified by those physician trainers in the current training program include the following:

- Trainees do not have an adequate understanding of the program's goals and are skeptical about becoming proficient in new areas in the time allowed for training.
- Training program managers are rarely present and do not provide leadership or oversight.
- The program is utilizing instructors who are not familiar with the Armenian context and who are not adequately briefed on the program and their specific roles.
- There are not enough patients visiting the training site to conduct clinical training.
- Some of the physician trainees appear to lack enthusiasm for the training, raising issues as to the method of selection.

AIHA, in its role as a PADCO subcontractor, will organize an additional training program in Vanadzor at Polyclinic #5. This training is being organized independently of that initiated in Polyclinics #1 and #4. This training program will serve rural practitioners (feldshers) and nurses and will strengthen their capacity to provide PHC.

ASTP is also working with counterparts to create a training program in family medicine at Polyclinic #17 in Yerevan. This program is to be taught by eight Armenian physicians who received special training through a World Bank program. PADCO will bring in two U.S. medical trainers to supervise this program. The program will provide clinical training to new physicians (or soon to be physicians) from the State Medical University and to doctors being retrained at the NIH. The NIH will continue to provide the theoretical aspects, and Polyclinic #17 will provide the clinical practice. Implementation of this program is contingent on the successful resolution of a number of issues with the clinic's management.

Presumably, all of these programs will prepare physicians to work as family doctors providing PHC services, perhaps in a FGP. However, ASTP correctly points out that the programs will not be identical. Those being trained in the various programs come with different backgrounds and experience. At the same time, the programs all need to convey the same basic knowledge and practice guidelines. It was unclear to the team whether such harmonization of programs is occurring.

- **Family Medicine: Creating Family Group Practices**

The objective is to set up FGPs and to demonstrate their effectiveness in providing PHC services.

Although much preparatory work had been done, no FGPs were operational at the time of this assessment. The first FGPs were expected to be operational shortly in Yerevan Polyclinic #17 and Vanadzor Polyclinics #1 and #4. ASTP also plans to establish five to eight family group practices at Erebuni Medical Center in Yerevan or Polyclinic #3. The Erebuni Medical Center FGPs have the potential to become self-sustaining more quickly because of the relatively high socio-economic status of the patients

that seek treatment at this facility. However, for that reason, it is not clear that this pilot has much applicability to the rest of the health care system.

The assessment team has some concerns (as undoubtedly does ASTP) about the readiness of the physicians, clinic managers and others to commence FGP operations. Polyclinic directors, for example, do not appear to see themselves as benefiting from the introduction of this program, suggesting that some adjustment in the incentive structure of the program may be needed. There is as yet no agreement on the financial mechanisms to support the FGPs, including the capitated payment scheme. On the demand side, ASTP has carried out a number of activities to inform the public in the catchment areas about these new programs. Those efforts will need to be expanded considerably as the FGPs are launched.

3. Constraints

STP's efforts to assist the MOH with health reform have faced a number of constraints. Not the least of these is the enormous complexity of the task. Unlike reform in the social sector, the health sector has thousands of employees who are products of the old system and whose roles will in many cases be fundamentally changed by reform. Particularly in a system that has excess capacity, it is not surprising that many of those people that are part of that system feel threatened by reform.

A second constraint relates to the capacity of the MOH to undertake reform. Although the MOH clearly has some very capable people, their numbers are small and their financial resources are small and declining. The impact of this situation can be seen in the difficulty that the MOH has found in taking the ASTP recommendations and putting them into practice.

This issue is exacerbated by the nature of the PADCO contract, which lays out a step-by-step plan and deliverables. An assumption underlying that plan is that the Ministry could keep pace, collaborating on and implementing the contractor's deliverables. The team believes that this assumption has not been confirmed, and this has led to friction between the contractor and the Ministry.

Finally, the team believes that ASTP has provided talented staff, but not always the right staff for the task. The difficulty that the contractor has experienced in recruiting a senior health reform expert appears to have been a constraint on progress to date.

C. NGO Service Delivery

Under STP, USAID directly supports four U.S. Private Voluntary Organizations (PVOs),³¹ which implement a variety of programs offering social and health services, income-generating public works, and NGO development programs. The programs target the needy in five marzes: Gegharkunik, Lori, Shirak, Syunik, and Yerevan.

This section provides an overview of those programs and considers whether they are consistent with and effectively implementing the STP strategy. As indicated above, under STP's strategy NGO programs are to provide assistance to the needy that at the same time test (or "pilot") new models for the effective delivery of social safety net services, to the extent possible identifying the most cost-effective way of paying for those services. The Mission hoped that inclusion of NGOs in this role would strengthen Armenian NGOs and lead to collaborative efforts with government (social partnership), enabling the GOAM and Armenian NGOs to extend an array of social, health and employment services to the needy over the long-term.

³¹ This report will generally use the broader term, Non-Governmental Organizations (NGOs), to refer to both the U.S. PVOs and the local NGOs.

1. Programs and Beneficiaries

Under STP, USAID/Armenia provides financial support through cooperative agreements to the Armenian Assembly of America (AAA), Catholic Relief Services (CRS), Save the Children Federation (SCF) and the United Methodist Committee on Relief (UMCOR). The CRS, SCF and UMCOR programs are intended to improve directly the quality of life for beneficiaries identified from among Armenia's poor. AAA's benefits are indirect. Its NGO Center (NGOC) program is intended to establish a stronger community of Armenian NGOs that can provide such services over the longer term. The CRS and UMCOR programs also include an element of "Armenian NGO strengthening," as they work in part through or in conjunction with Armenian NGOs. Table 3 shows STP's principal NGO programs.

Table 3
STP's NGO Programs

NGOs	Program	Key Objectives/Activities	Beneficiaries
AAA	NGO Center (NGOC)	Provides training and small grants to strengthen the capacity of Armenian NGOs; works with government to strengthen the environment for NGOs in Armenia.	Direct benefits to 318 NGOs that participate. The poor will benefit indirectly from their services in the future.
CRS (with Armenian NGO Caritas)	School Feeding	Organizes parent councils (Parent School Partnerships) to manage the building or refurbishing of school canteens and to oversee school feeding activities.	Provides cold lunches to 12,000 children in 40 schools located in poor communities.
SCF	Public Works	Creates income-earning opportunities for needy families; organizes Community Action Groups (CAGs) to refurbish facilities in poor communities. CAGs hire the most needy unemployed workers for two months.	Over three years, will provide 4,000 short-term jobs in 33 communities. Facilities refurbished provide permanent employment to another 174 workers.
UMCOR	School Feeding	Provides free noontime meals; develops school gardens to augment supplies/income.	Provides meals for 6,000 children in 20 schools.
	Students' Cafeteria	Provides a nutritious meal to poor post-secondary level students in Yerevan.	Provides meals to approximately 200 students.
	Soup Kitchens (through Mission Armenia)	Provides meals for the elderly, disabled and destitute.	18 soup kitchens provide approx. 2,700 meals daily.
	Mobile Medical Teams	Provides primary health care (PHC) services to the citizens of 11 villages otherwise without care.	Provides approx. 760 consultations per month in 11 remote villages.
	Medical Insurance Fund	Establishes insurance-based rotating drug fund system in villages.	12 village-based funds serve 3,510 people.
	Noah's Ark	Provides a pregnant farm animal to poor families. Recipients are expected later to donate a similar animal to another family.	746 families in 14 communities have received animals.
	Community Centers (through Mission Armenia)	Provides community-based, integrated social and health services to the elderly and disabled; provides home care, as needed.	3 feeding centers are now providing these services.
	Training of Community Health Workers	Provides training to volunteer community health workers who serve in remote villages.	Approx. 248 health workers have received training.
	Seasonal Delivery of Food Parcels (through Mission Armenia)	Provides food parcels during the winter to vulnerable families.	Approx. 40,000 families have received parcels.

NGOs	Program	Key Objectives/Activities	Beneficiaries
	Health Education	Provides health education to school children and their teachers.	Provided initial training for 4,847 children and 77 teachers.

2. Targeting

STP's NGOs typically take considerable care in targeting their activities to the most needy. Many of the programs take advantage of the PAROS assessments to determine the relative need of different families. Frequently, as in the selection of workers to participate in **SCF's public works program**, PAROS data are supplemented with assessments carried out by community leaders who are familiar with the situation of families in their town.

A number of programs target poor villages and do not differentiate among the families within those villages. **UMCOR's Mobile Medical Team (MMT)** and its **Medical Insurance Plan** choose villages without medical services and without a regular supply of pharmaceuticals and provide services for any families within those villages. As each program has relatively high fixed costs and low marginal costs, limiting participation would not make sense. However, if the MMT moves toward some form of limited cost-recovery (as the assessment team believes would be advisable), UMCOR might try to establish a two-tier pricing scheme based on ability to pay.

The **CRS School Lunch** program is similar with respect to targeting. The program has chosen 40 schools where the children are believed to be among the most vulnerable. It then provides school lunches to all of the 11,500 children in those schools without trying to identify those who are most vulnerable. The program's cold lunches meet about 30 percent of the children's daily caloric needs at a cost per meal of approximately AMD 200 (\$0.37).

UMCOR's School Lunch program, in contrast, does differentiate vulnerable and not vulnerable children within the schools it serves. It provides free lunches to approximately 6,000 of the 11,000 children in the 20 assisted schools. As in the CRS program, lunches are limited in nutritional value, providing about 20 percent of the children's daily caloric needs. UMCOR has experimented with the provision of lunches to the less poor children for a fee, thinking that those children could pay the real costs of their lunches and perhaps even cross-subsidize the needier children. Were that possible, the cross-subsidy would lower the cost to a future funding source and help to make the program sustainable. However, almost no children purchased the meal when it was sold for the 100 AMD (\$0.18) real cost. UMCOR is now selling the lunch to the less needy children for 40 AMD (\$0.07) and still finding little interest. These results suggest that the difference in vulnerability between the children identified as vulnerable and those who are not may be quite small, since the non-vulnerable families are apparently unable to afford even the highly subsidized price. Nevertheless, the UMCOR experience shows that it is possible to target only the most needy children for the fully subsidized lunches within a school, provided that parents and school administrators understand why this is being done and there is transparency in the process.³²

UMCOR's Students' Cafeteria provides one nutritious meal (providing about 50 percent of caloric needs) to about 200 needy university students. UMCOR estimates that these meals cost approximately 700 AMD (\$1.27), about seven times the cost of an UMCOR school lunch for younger children. Although the assessment team was not able to visit this activity, it questions whether the need to provide assistance to this group is as great as it is for other groups. Children of the poorest families in most countries do not reach post-secondary education, and poor students who do reach that level can usually find some type of part-time employment to earn enough to eat. Further, younger children are more vulnerable to nutritional deficiencies.

³² In this sense, UMCOR's experience mirrors that of the MOSS and PADCO in the reduction in the number of Poverty Family Benefit (PFB) recipients. Families accepted the new rules when they were carefully explained and the process was transparent.

UMCOR reports that setting up a special eating facility in the university environment has raised the issue of social stigma. UMCOR has attempted to address this issue by offering meals at a price of 400 AMD (\$0.73) to students who would otherwise not qualify for the program. The 300 AMD (\$0.54) per meal subsidy to the non-vulnerable in this program obviously reduces the funding available for the truly needy. However, as only a dozen or so students a day are taking advantage of this program, the diversion of resources is very small. (A more serious concern about this program, its cost-effectiveness, is discussed below.)

NGOC programs, of course, target NGOs rather than the poor. However, NGOC's programs for Armenia NGOs include training in methods of targeting, including use of the PAROS system.

3. Humanitarian Impact

The numbers of beneficiaries for many of the NGO programs is shown in the table above. These numbers, although large, represent only a fraction of the needy in Armenia. However, they are quite significant when viewed as a supplement to the various other programs financed by the GOAM and other donors. The most significant of those programs is the government's Poverty Family Benefit, which is being provided to 160,000 families in 2002, approximately 20 percent of the Armenian population. The World Food Program (WFP) provides food for 55,000 families, distributed by regional centers using the PAROS system. Many international NGOs are also active in Armenia, providing food, clothing, pharmaceuticals, assistance with shelter, and meeting other needs.

A number of the assessment team's interviewees raised the issue of dependency, i.e., suggesting that food and other handouts might be changing the outlook of the traditionally proud and independent Armenian people. The team's limited contact with recipients of assistance suggested a strong preference for work over welfare. From the viewpoint of avoiding welfare dependency, programs like the SCF public works program that provide income for work, leave a physical asset rehabilitated and generate some permanent employment opportunities, have an advantage over programs that simply provide humanitarian relief.

4. Development Impact

Most of the NGO programs supported by STP are appropriately considered social or humanitarian relief programs rather than economic development programs. Nevertheless, many of the programs do have the potential of generating longer-term positive economic impact. A useful way of thinking about this issue may be to ask whether the NGO programs subsidize consumption or investment. For example, the CRS and UMCOR school feeding programs provide a subsidy to consumption, and they also have an investment aspect in that they further the ability of children to learn. The CRS and SCF programs also have civic action components that should be thought of as an investment or development activity.

With respect to the **CRS and UMCOR School Lunch Programs**, experience in other countries suggests that school feeding programs make some contribution to improved school attendance, children's alertness in the classroom and learning. Such programs thus contribute indirectly to increased school efficiency and to human capital development. Positive impact on nutrition lowers morbidity and health care costs. Anecdotal evidence suggests that these STP programs are having similar impacts, at least on school performance.

The **CRS School Lunch Program** also includes a community organization and mobilization scheme that offers potentially important development benefits. CRS's use of Parent School Partnerships to help administer the school feeding program encourages greater parental involvement in schools (generally quite low in the former Soviet Union), which is generally recognized as a way of improving school quality and performance. **SCF's Public Works Program** includes a community-organizing component

that may be a force for development over the coming years. These activities also address the need to increase public participation in governance.

5. Cost-effectiveness

The assessment team's ability to consider the cost-effectiveness of the various programs was constrained by the available data, time and staff resources. The following paragraphs raise a number of concerns that have emerged from the team's interviews and study of relevant documents.

SCF's Public Works Program is the only STP program with the objective of generating income for vulnerable families. This factor sets it apart from programs that primarily provide humanitarian assistance. In the 33 communities in which it is operating, SCF's public works program has afforded temporary work opportunities to approximately 4,000 unemployed workers from families with little other income. About 2,000 workers received one month of employment (during the first year of the program) and the other 2,000 are employed for two months. The monthly salary paid to an unskilled worker (the most common skill category) is 50,000 AMD (\$90). (The reported average wage in Armenia in 2001 was 23,000 AMD, \$41.44.) The assessment team's observations and interviews showed that those given temporary employment were grateful for the opportunity to work and worked hard, and the income generated was very helpful to their families.

SCF's program does more than provide employment. It helps communities to organize and to take responsibility for their well-being, it builds local self-confidence, and it rehabilitates a valuable public structure. SCF data show that those rehabilitated structures have generated 174 permanent jobs. Despite these benefits, a troubling aspect of this SCF program is that only about 15 percent of the USAID-provided resources are utilized for the payment of workers on the various community projects. Other major expenses include construction materials, supervisory services, transportation, oversight and management expenses.

The assessment team questions the cost-effectiveness of **UMCOR's Student Cafeteria**, although time did not permit detailed analysis of this issue. The number of targeted beneficiaries is small. The provision of food in a special facility that provides only one meal a day for a group of limited size is expensive. There are probably more cost-effective methods to reach the small number of targeted students.³³

The UMCOR Mobile Medical Teams (MMT) program provides consultations, laboratory tests and medicines. Assessing the cost-effectiveness of this program presents many methodological issues, not the least of which is determining the "effectiveness" of the service as compared with alternatives. The cost per unit (each service to each individual being counted as a unit) is about 1,000 AMD (\$1.80), extremely high compared with the capitated rate that the MOH pays to polyclinics for care. Although transporting physicians to patients is not cost-effective where doctors' salaries are high, it may be cost-effective when those salaries are low and where the doctors can see many patients who would otherwise each need to

³³ If the needs of these students are truly as great as those of other groups served through UMCOR programs, UMCOR might wish to consider other options for reaching them. For example, the same meals might well be provided to the same students at a lower cost by contracting competitively with a commercial establishment already in operation and serving the general public. This solution would avoid the problems that are apparently arising with one or more restaurants in the same geographic area that resent the competition from the UMCOR facility. Further, setting up a special eating facility in the university environment has raised the issue of social stigma, addressed through the project by offering subsidized meals to students who would otherwise not qualify for the program. This obviously reduces the funding available for the truly needy. Other more cost-effective alternatives might be to provide needy students with vouchers that would be acceptable in several local restaurants (i.e., pre-negotiated by UMCOR) or to simply provide a cash stipend to the needy students. (Vulnerable students at the university level should be sufficiently mature to use cash payments appropriately.) Any of these options would reduce the management burden. There would be no social stigma and no need to provide assistance to less needy students.

travel the same distance. Consideration of these issues is beyond the scope of the present assessment. It may merit attention as part of an analysis of how the MOH could best provide PHC services to the dispersed Armenian population.

6. Sustainability

As indicated above, the STP strategy called for NGO partners to determine the most cost-effective way in which their programs could be financed. As many of the programs provide support to the poorest Armenians, STP's planners apparently concluded that cost-recovery would be an unrealistic goal. The assessment team concurs with that conclusion: most of the STP NGO programs currently being implemented could not be sustained through any type of user fee or income generation scheme.

School lunch programs, for example, can be sustained and replicated only with government, donor or community support. The prospects for such support are not encouraging, although efforts to generate community support have not been seriously tested. GOAM support in the longer term might be forthcoming. When Armenia was part of the former Soviet Union, Armenian students in grades 1-4 did receive food at school. If the Armenian economy grows and resources become more plentiful, it is possible that the GOAM would recreate such a program.

UMCOR'S school lunch program includes a component that aims at developing **school gardens** in the schools where the school lunch program operates. The program provides seeds, tools and other materials, plus two people (who also manage the school lunch program) to plant, maintain and harvest the garden. Some schools reported having used the garden to teach related science subjects. Products from the gardens are intended to supplement the feeding program or to be sold for cash that would in turn be used to purchase supplemental food for the feeding program.

The school garden activity does not appear to have a direct humanitarian or development impact on vulnerable groups. Rather, this program appears to be a school-based business designed to sustain (cross-subsidize) the school feeding program, thereby producing important and sustainable indirect benefits. This is a laudable goal, and one that merits support if it can be shown to work. To test the scheme's viability, UMCOR will need to maintain an accounting system for this activity that will allow it to determine whether the gardens pay for themselves, much less subsidize school feeding. Experience in other countries suggests that it is difficult for public sector socially-oriented organizations like schools to run profitable businesses, particularly when those activities are not related to its core functions (in this case, education).

The **UMCOR Medical Insurance Fund** is a program that attempts to generate resources from the community to offset its cost, at least partially. The program is currently aiming at only 65 percent cost recovery. It is difficult to see how the schemes can survive longer than the current grant period unless the GOAM were to agree to provide the needed subsidy. Given the state of the Armenian economy and its public sector finances, such GOAM support is not likely. Some adjustment to the program, perhaps with technical assistance from the PADCO/Abt group, might increase the likelihood of sustainability.

7. Support for Armenian NGOs

AAA/NGOC is STP's primary vehicle for strengthening Armenian NGOs. NGOC has provided services (primarily training) to 318 Armenian NGOs, including many that are not among the 183 NGOs registered with the program. Occasionally, local government officials have participated in training sessions, helping to build relationships between government and the NGO community. NGOC also awards small competitive grants, mainly for capacity development. NGOC is working to improve the legislative environment. Presently, Armenia's NGO law prohibits NGOs from undertaking any commercial activity, a stipulation that is understood to effectively prohibit them from receiving contracts from the government.

The CRS and UMCOR programs also strengthen local NGOs that act as partners in the implementation of some of all of their STP-financed activities. SCF does not work with an Armenian NGO partner.

The GOAM has made several attempts to reach out to NGOs to involve them in discussions of specific pieces of legislation or to participate in national conferences. (See Section III.E. below.) Government efforts to create an association of NGOs in specific sectors have failed.

D. The Effectiveness of Integration as an STP Approach to the Social and Health Sectors

As noted in Section II. D, a key element of the strategic design of the Social Transition Program is integration of technical assistance activities for social insurance, social assistance, and health reform activities. This approach explicitly recognizes the interrelationships among problems and issues in the social and health sectors. A single contract was awarded for the policy development, structural reform, and capacity building components of the STP for both the social sector and health sector.³⁴ The STP strategy anticipated that reform initiatives would be pursued jointly for both sectors in hopes that there would be synergies or efficiencies to be gained from an integrated approach. Sequencing of projects and activities could be designed to take maximum advantage of activities implemented in one sector for the other sector and to use lessons learned effectively. When the concept was developed, the MOSS and the MOH had been combined, so USAID anticipated that the STP contractor would be working with counterparts at a single ministry. When the STP actually got underway in August 2000, the two ministries were again separate. This affected the implementation, but it did not change the strategic approach of pursuing an integrated approach to reform in both sectors.

1. Potential benefits of integration

The integrated approach to social sector and health sector development has significant potential benefits. In general, it provides a more comprehensive approach to meeting the needs of the vulnerable population. Generally, lower income and more needy families have low and often inadequate consumption of food, heating and other energy, and also have more health problems and less access to health care. Addressing needs in one area affects vulnerabilities in other areas.

An integrated approach maximizes the impact of limited technical assistance and investment resources. STP is developing staff of highly skilled persons in specific areas. In some areas in Armenia there are not yet sufficient opportunities to fully utilize these highly specific skills and capabilities. By broadening the areas and range of problems on which they are engaged, the integrated approach increases the applications for the skilled and highly specialized and costly human resources that STP is training and developing and makes more efficient use of these resources.

- The **actuaries**, whose training is supported by PADCO, can work on social insurance reform issues, social assistance, health insurance and health care finance. The actuaries currently are not fully utilized. The opportunity to work in several related areas increases the number of projects they work on and broadens their experience and skills.
- PADCO staff **lawyers** with expertise in social sector reform in the Armenian context can work on legislation in both the social sector and health sector, broadening their experience and expertise. PADCO has used lawyers from the U.S., Canada, Chile, and other CIS countries to work on legislative reform and advise GOAM personnel and Armenian PADCO lawyers.
- **Social workers** can integrate social and health service delivery. Given the budget constraints of GOAM ministries and the lack of adequately trained social workers, current and future social workers should be utilized efficiently.

³⁴ These were identified as components one and two and part of component three of the *Social Transition Program Concept Paper* and the Work Statement of the Request for Proposals and the contract. These components are identified in the Executive Summary of this report.

- **Survey database** collection and analysis is costly and requires highly skilled personnel. Data collection and analysis resources can be applied jointly to both social sector and health issues with great efficiencies and improvement to the usefulness of the surveys.

By tendering one contract for work in both the social and health sectors, USAID may have hoped to reduce contract preparation and administration burdens.

Table 4 shows potential areas for an integrated approach to social sector and health sector reform.

Table 4
Examples of the Integrated Approach to Social Sector and Health Sector Initiatives

Social Sector Initiatives	Health Sector Initiatives
Assigning personal identification numbers	Patient caseload records and referrals
Personified reporting of wages, pension contributions and benefits	Foundation for health insurance
Computerization of births, deaths, and marriages	Creation of health mortality indicators
Integrating social services caseloads	Patient referral to social services
Disability pension eligibility determination	Referral to health and rehabilitation service
Targeting social assistance programs	Targeting free medical benefits
Legal basis for social insurance	Legal basis for state health insurance
Procedures for working with NGOs and private social service providers	Procedures for working with private health care providers
Surveys of consumer satisfaction with social services	Surveys of consumer satisfaction with health services
Improvement of Household Income and Expenditure Survey to analyze household needs	Analysis of out-of-pocket health expenditures and household health needs
Training of MOSS personnel in computer skills	Training of MOH personnel in computer skills
Public education about pension reform, social assistance and Personal Numbers	Public education about health care reform and healthy personal behaviors
Actuarial skills applied to pension reform and social assistance policy analysis	Actuarial skills applied to health insurance and health care finance reform

2. Areas where integration has been effective

Integration has been effective in a number of areas and has reduced the costs of the project.

Development of laws

A single staff of PADCO lawyers works on legislation in both the social insurance area and health care sector. The same legal basis and understanding of social insurance concepts are applied in both areas, so they will have a consistent legal framework. For example, the same principles of social insurance apply to reform of state pensions, disability insurance, and state health insurance. The same principles of transparency and consumer protection apply to private pensions and to private health insurance. Economies of scale in use of staff, support and administrative resources reduce costs relative to that of conducting separate projects in the two sectors. Legislative developments have been sequenced to take advantage of experiences gained and lessons learned both in developing new legislation in the social insurance area and in presenting it to the Government and the Parliament.

Information technology

PADCO and the Mergelyan Institute (YICRD) have designed IT systems for both the social sector and the health sector. Designers and programmers in both organizations work on both social and health sectors. IT systems are designed to be consistent between the two sectors and to facilitate linking them. In some cases the same system can be used in both sectors. For example, the initial design of the PN system was only for use for pensions. Under STP the redesigned PN and personified reporting system can be used for pensions and for health insurance. The PN may also be used for the Health Information System

(HIS) being designed at PADCO for the MOH. The integrated approach encourages system designers and programmers to approach tasks on a system-wide basis. Economies of scale and increased experience of IT personnel working in both sectors reduce costs and improve functionality. The PN development has been sequenced for maximum advantage. The legislative basis and political support have been developed primarily in the context of pension reform, where a consensus on the direction for reform has been developed within the GOAM. The pilot program is being implemented by MOSS in a Regional Social Security Office, where pensioners, social assistance beneficiaries, and unemployed recognize the benefits of being registered. After analysis of the pilot and the beginning of national implementation, it will potentially be much easier to apply the PN to other social and health sector programs.

Targeting

Both the MOSS Poverty Family Benefit and the MOH Basic Benefits Package use the PAROS-based eligibility system to target benefits. MOSS and MOH are now thinking jointly about targeting. As MOSS continues work to improve the targeting system, with support from the World Bank and STP, its use for both social assistance and health care benefits, as well as potential use by NGOs for targeting benefits, can be taken into consideration. Lessons learned in improving the targeting of the Poverty Family Benefit and in educating the public to promote acceptance of the more restricted targeting of the benefit may be applied to efforts to refine the targeting of health benefits.

Training

PADCO counterparts in both MOSS and MOH at both the central and regional levels participate in common training programs for computer skills, statistical techniques and applications, management, principles of social insurance and reform and other topics of common interest. In this way, personnel at the staff level interact, learn what the other ministry is doing and share ideas. For example, social insurance concepts apply both to protection of income and provision of health care. Conducting joint training courses also reduces costs.

Public information

PADCO public information advisors support both MOSS and MOH activities. This provides economies of scale and helps develop a consistent message for both ministries. Lessons learned in the public education campaign and the information exchanged with lawmakers accompanying the discussion and passage of pension reform legislation in 2001 and 2002 can be applied to the development of health reform legislation and other social insurance legislation.

Household surveys

The Integrated Household Survey of Living Standards conducted by the NSS with PADCO support has questions about income, expenses, social assistance, health and health care utilization and serves both sectors. The STP survey of use, knowledge and perception of social services also covers both social sector services and health facilities and is used to monitor and evaluate activities in both areas.

Service Delivery

The only successful example of integrated delivery of social and health care services is the Mission Armenia (UMCOR) Community Center Program, described in Section E below. Lessons learned from this activity could be applied by MOSS and MOH, as well as other NGOs, in the development of a comprehensive approach to meeting the social and health needs of the vulnerable population.

3. Areas where integration has not been applied or has not occurred

STP efforts to integrate social and health sector reform activities are essentially limited to activities within the PADCO contract. Activities carried out by PRIME II/Intrah, MACRO and under the AIHA partnership program are focused entirely on health. The assessment team saw no indication that the AIHA activities now getting under way under the PADCO contract will be integrated with other PADCO activities.

With the exception of the Mission Armenia (UMCOR) program, described below, none of the NGO programs appears to involve an integrated approach to social and health sector activities. Each has a focus in a particular area in one sector. The prospects and potential benefits of integration of social and health activities for NGOs may be limited. Each NGO appears to function independently of the other STP partners. There is little integration or coordination. With the exception of the PADCO staff, the STP partners do not behave as a team.

4. Costs of integration

Carrying out social sector and health sector reform activities under one contract creates a large and complex program. Management is more difficult and requires greater resources. Integration has posed challenges to both USAID and PADCO.

- The USAID project management team has had to monitor a large and particularly complex project, involving different GOAM ministries and agencies with very different capabilities and orientations toward the STP. The program involves numerous contractors, subcontractors, grantees and sub-grantees, and dozens of national and local government counterparts.³⁵ The project has also involved issues of GOAM ministry and agency capabilities and politics and contractor/subcontractor/NGO capabilities and relationships, as well as coordination among international donors in both sectors. Interestingly, interviewees in each sector (social and health) expressed the opinion that the other sector received more management time and resources from USAID. Had there been separate projects in the social sector and in the health sector, with separate USAID management teams for each, the management burden on each team would have been less, and greater attention might have been focused on each sector. However, the total management burden, staffing and time requirements for the Mission might have been greater, and the substantive benefits and efficiencies of integration would not have been achieved.
- PADCO has had to manage a larger and more complex organization to carry out multiple projects in both sectors than if it were working in one sector alone. PADCO/Abt has a resident staff of 56 in Armenia, including seven resident advisors and about 30 Armenian specialists and consultants. In addition, PADCO has used about 20 third-country nationals on a short-term basis (many with multiple visits). Had the STP not attempted to integrate activities in social and health sectors, this complicated and cumbersome management structure would not have been necessary. The subcontracting arrangements took time, effort, and management attention to work out and complicated and delayed the beginning of work on the health side. (Although some of AIHA's activities in Armenia are conducted under a subcontract with PADCO, it appears to operate almost entirely independently, with little coordination with PADCO or other STP partners.)
- In a complicated project with multiple activities and objectives – some integrated and some not, multiple counterparts with widely varying capabilities and approaches, and multiple implementing organizations with varying capabilities, styles and approaches, management attention and responsibility are inevitably more diffused than if the components were in separate projects, each of which had a separate and less complicated management.

5. Constraints

The major constraints on whether integration of efforts in the social and health sectors will achieve all of the potential benefits are the ability and willingness of MOSS and MOH to coordinate programs and activities, and the ability and interest of MOH to pursue and implement potential capabilities that have been developed through integrated reform activities – in legislation, information technology, public

³⁵ UMCOR's website-based list of communities in which there is some STP activity is more than 15 pages in length.

education, training, and other areas. Reform appears to be more complex and potentially more difficult in the health sector than in the social sector.

There may be significant limitations to the potential applicability of the integration context in other USAID missions. Armenia is a relatively small country, with a homogeneous population and relatively homogeneous economy. The USAID program is of moderate size but relatively well funded on a per capita basis. Integration may be more difficult in a larger country with a more diverse population and economy.

6. Assessment and prospects for future progress

Although it has increased management burdens, the STP integrated approach to reform and development in the social and health sectors has significant benefits for both social sector and health sector reform. (Interestingly, both the Minister of Social Security and the Minister of Health told the assessment team that they endorsed the integrated approach.) The actual and potential benefits of integration enhance its future prospects, especially as both sectors advance. Under an integrated approach it is more likely that there will be a convergence of policy concerns between the two sectors.

- Pension reform will focus on development of personalized nominal accounts and, perhaps eventually, individual funded accounts. Health care finance will involve consideration of national health insurance.
- The state pension could be augmented by the development of non-state contributory pensions and perhaps employer group pensions. Non-state health finance arrangements could include open-enrollment or group capitated plans.
- Information technology requirements in both sectors will be similar and will involve linking or integrating databases.
- Public education will play a vital role in both sectors in promoting public understanding and support of reforms and socially, economically and physically healthy behaviors.

E. The Effectiveness of Linkages as an STP Approach

The STP strategy anticipated that bringing NGOs into an integrated program to improve the provision of social and health services would allow NGOs to pilot test new delivery strategies, encourage NGOs and government to collaborate in a type of “Social Partnership,” and provide an environment in which Armenian NGOs could grow and assume a more active role in service provision. This section will review (1) whether the NGO programs can be considered pilots, (2) the extent of communication and collaboration between the NGOs and the STP partners working on reforming government systems, (3) the extent to which these groups have succeeded in building a social partnership, and (4) whether STP has contributed to strengthening Armenian NGOs.

1. NGO programs as pilots or models

USAID has encouraged STP’s NGOs to experiment with new types of service delivery that might prove to be cost-effective models which could be replicated by government and by other NGOs. USAID’s strategic plan indicates that NGOs would be involved in “an intensive effort to test new approaches to service provision.”

The portfolio of STP-supported NGO programs includes activities that are innovative in the Armenia environment and which could provide valuable lessons to those in the public and private sectors responsible for planning and implementing social and health programs. UMCOR, for example, has several programs that clearly qualify as pilots. One of these is the **Medical Insurance Fund**. A better name for this program might be *Medicine Insurance Fund*, as it is essentially a revolving drug fund financed by monthly payments, instead of more common user fees. This is clearly an innovative idea and

one that, if successful, could prove very useful. To date, the program has found it difficult to attract a sufficient number of families, and this affects the program's financial viability. The limited interest may be due to the fact that Armenians have had no experience with private insurance. Under the Soviet system, the government was the insurer, and the costs were hidden from the public in payroll taxes paid by state-owned enterprises. There were no individual payments of insurance premiums. Another problem is poverty; the poor who most need this program have the most difficulty paying the small monthly premium.

UMCOR hopes to raise participation in the Medical Insurance Fund so that it can reach 75 percent cost-recovery. The implied assumption seems to be that the government might eventually pick up the extra 25 percent, although this seems questionable in the present economic situation. Yet another problem is that voluntary insurance schemes, such as this one, run the risk of "adverse selection," an insurance term meaning that those most likely to affiliate are those most likely to need services. In this case, families likely to need medications have a much greater incentive to join than families that are less likely to need medications. To partially protect the solvency of the program from this danger, the program raises the premiums for families that have a chronically ill member.

Another program supported by UMCOR is the **Mobile Medical Team (MMT)**. MMT is testing the provision of services to 11 remote, poor villages that would otherwise be without medical services. The mobile clinic has three doctors who appear to function somewhat as a mobile family group practice. Without the twice-monthly visit of the UMCOR mobile medical team, the populations of these villages would often elect not to go to the expense of traveling to the nearest medical facility. Although moving doctors around the region is costly, it may, in fact, be cheaper to move three physicians to a village for a day rather than 100 villagers to the nearest medical facility. This experiment would appear to warrant monitoring from the PADCO/Abt team and/or from the MOH. If this model proves to be cost-effective for the delivery of health services to remote areas, it might also be useful as a delivery mechanism for selected MOSS social services.

One of the most exciting NGO "pilot" activities in the STP portfolio is **Mission Armenia's Community Center Program**. This program provides integrated, case-based social and health services in a community setting. In this program, Mission Armenia community centers in Yerevan, Gyumri and Sisian that started as feeding centers for the elderly poor now offer medical, limited mental health and trained social worker services. Social services, organized by a social worker attached to each center, include noontime meals, legal services, games, television, and a variety of social events. With respect to health, seven physicians hired and specially trained by the NIH provide a variety of primary health care services oriented particularly to the aged. The social and health staff work together as a team, meeting regularly to identify the needs of each eligible beneficiary, to define a set of services to meet those needs, and to monitor progress. Transportation is available for beneficiaries otherwise unable to go to the community center. For beneficiaries unable to come to the community center for services, even with transportation provided, team members travel to the beneficiaries' homes to provide services.

The centers provide much needed care for the elderly that is likely to permit them to remain in their communities, providing a less costly alternative to institutionalization. This Mission Armenia program provides a rare example in Armenia of integrated delivery of social, health and nutrition services outside of an inpatient, institutional setting.³⁶ It extends *integration* to service delivery – a level considerably beyond what exists in any other part of the STP. Rather than expecting the individual to deal with different institutions for income support, food assistance, housing, medical services, mental health needs, etc., this program attempts to treat all of the individual's needs together. Just as the STP's focus on family

³⁶ The evaluation team did not have time to make an assessment of all other programs in Armenia. The team did hear about a program sponsored by the Red Cross, which may also provide community-based, integrated social and health services.

practitioners attempts to view the person's medical needs jointly, the Mission Armenia program moves a step further and deals with a broader suite of needs jointly.

The **CRS school feeding program** and the **SCF public works program**, although modeled on programs these institutions carry out in other countries, are unique and somewhat innovative in the Armenia setting. The unique feature of these programs is their organization of voluntary community action groups that take responsibility for the management of programs in their respective communities. The organization of such groups, if they continue after the period of the externally-financed project, might play an important role in the future in strengthening communities. SCF indicates that it has created some 345 such groups in Armenia, although it is not known how many remain active. Aside from their potential role in addressing social problems associated with poverty, civic action groups also contribute to the deepening of a democratic, pluralistic society. Innovative, of course, is not synonymous with useful or replicable. The programs mentioned above appear to offer potentially useful and replicable models, but this determination will require further data collection and analysis.

2. Communication between the program's macro and micro elements³⁷

As "good communication" and "collaboration" are almost universally accepted as positive values, it was not surprising that all STP partners indicated that they favor better NGO communication and closer ties with government and with organizations like PADCO, Abt and PRIME that operate on a national level. There have been a number of attempts to organize regular fora for these groups to discuss issues of mutual interest and to consider joint activities. These attempts have not been successful. STP's internal effort to establish a regular forum for discussion and collaboration – the quarterly meetings of all of the partners – are described by the participants as essentially "show and tell" meetings in which each participant describes his/her organization's activities. The participants at those meetings who were interviewed for this assessment did not find those partner meetings productive. Fewer partner meetings are now being scheduled.

Although there are examples of successful short-term collaboration (e.g., working together on a commission or on a draft law of mutual interest), almost all observers described the communication among the groups that focus on implementation at selected local sites and those that try to develop effective national policies and programs as sporadic at best.

The evaluation team heard from both MOSS and MOH officials that they would like to be better informed about NGO activities. Although the Ministries insist that they do not wish to control NGOs, they do speak of the "need for Ministry approval of NGO activities" and of licensing NGO activities. This may explain why NGOs have been reluctant to become involved with the central government. The team observed a number of instances in which NGOs had frequent, close and harmonious communications with marz and community-level officials.

3. Social Partnership

STP's linkage strategy, which calls on NGOs to pilot test models to deliver social, health and employment services, heightens the importance of government-NGO collaboration. Thus, STP has sought to strengthen the collaboration between these groups. USAID assigned PADCO responsibility to work with government to create an environment conducive to NGO growth and to encourage government to seek ways to collaborate with NGOs. USAID assigned NGOC responsibility to work with the NGO community to encourage it to collaborate with government.

³⁷ The evaluation team understands, in the STP context, the term micro to mean relating to humanitarian direct assistance, generally short-term projects, and macro to mean relating to reform and capacity building, generally longer-term projects.

PADCO and NGOC have conscientiously attempted to carry out their responsibilities. The two organizations have met on occasion, but these meetings do not appear to have resulted in a common approach or collaborative activities. PADCO, for its part, has worked on legislation and encouraged MOSS and MOH to welcome NGO collaboration. One result is that the MOSS is creating a space for NGOs to be represented in the planned integrated social service center in Vanadzor. PADCO developed and published a brochure listing the Lori marz NGOs and the services they offer. This brochure was thought to be an activity that the MOSS might replicate in other marzes. However, USAID felt that this activity, if it went forward, should be spearheaded by NGOC on behalf of NGOs rather than by government. NGOC did not replicate this activity, and it appears to have halted.

National governments are interested in knowing what NGOs are doing, even if the NGO's programs are fairly small in scale and operate in a limited number of localities. This is certainly the case in Armenia. The Ministers of Social Security and of Health each expressed a strong desire to know what NGOs are doing, where and for whom. The needs of the central government are different from those of local governments. The Minister of Health argued convincingly, for example, that the Ministry has a legitimate need to know what health practices NGOs are advocating, to ensure that medicines being brought into Armenia are appropriate and not passed their expiration dates, and to ensure that medical care is provided only by those trained and licensed to do so. Similarly, the Ministry of Social Security would like to know who is receiving benefits distributed by NGOs so that it can take that benefit into account in deciding which families will receive the government's Poverty Family Benefit.³⁸

The Government's perspective on the NGO community appears to be somewhat mixed. Several officials indicated that cooperation is limited by the weakness of Armenian NGOs. One senior government official described them as being like children experiencing growing problems. That official claimed that an annoying symptom of immaturity is that NGOs sometimes behave like political parties, opposing government policies just to attract attention and the support of other youthful groups and individuals.

Several government ministries have brought NGOs together on an *ad hoc* basis to work on specific issues (e.g., legislation relating to the protection of children) or to form a permanent forum for NGO-government exchange. The results of these efforts are mixed. In one case, the NGOs invited were perhaps not the appropriate group to participate in the subject area under discussion. In other cases, NGOs have appeared reluctant to participate in government initiatives. One of the more successful areas of collaboration appears to be between NGOs and the MOSS Department of Disabled Affairs. That department is cooperating with 15-20 local NGOs. Cooperation with NGOs is important for this department because budget constraints limit the projects it is able to carry out, and NGOs provide resources for some projects. In one collaborative effort, the department and PADCO jointly produced a booklet with information for the disabled. PADCO printed the booklet, and it is being distributed by NGOs that work with the disabled.

NGOC also has made attempts on behalf of the NGO community to participate in government activities and to organize the participation of its affiliates. These efforts do not appear to have led to significant increases in NGO-government collaboration. NGOC believes STP has offered NGOs higher visibility with government and with USAID contractors. NGOC suggested that the use of common success indicators (for social services) might provide common ground for those thinking in terms of national systems and those focused on services at individual facilities.

³⁸ This information request is controversial. NGOs are reluctant to see the very vulnerable families that they assist "penalized" by the government for accepting the NGO's support. There may also be privacy issues involved in releasing such data to the government unless the recipient was advised and consented to the NGO providing that information. Although such privacy issues have not in the past been seriously considered, a new privacy bill developed with PADCO assistance and expected to become law soon would apparently make the release of these data illegal without the person's prior consent.

NGO relations with government are best at the local level. To the extent that NGOs deal with government, it is often about specific implementation issues and is typically with officials that have responsibility for the specific geographic areas that the NGOs are serving. In Armenia, this brings the NGOs into contact with marz and local officials.

Discussions with representatives of CRS/Caritas, SCF and UMCOR/Mission Armenia -- STP NGOs that operate programs in the field -- indicate that these NGOs have excellent relationships with local government. The evaluation team's discussions with a sample of local officials and its observations are consistent with that assessment. From this perspective, an excellent NGO-local government social partnership can be said to exist, although it does not appear to be the result of any specific STP strategy.

The weak state of most Armenian NGOs is a factor limiting their ability to be partners with government. The government also has serious financial constraints, making the idea of contracting out to NGOs both financially and politically difficult. The legal framework is also an obstacle to contracting out. The NGO law currently in effect would prohibit NGOs from undertaking "commercial activities," meaning that NGOs would need to change their legal status in order to accept government resources.

For these reasons, STP has made little progress in strengthening the social partnership between NGOs and the GOAM.

4. Strengthening Armenian NGOs

While AAA's NGOC is the only STP effort for which the development of Armenian NGO capacity is its primary objective, this objective is shared with virtually all of the other STP partners. (USAID/Armenia also supports other programs that are outside of the STP framework and which are aimed at NGO development.)

CRS's involvement of Armenian Caritas as a partner presumably is having a positive effect on that organization's capacity. Similarly, AAA is creating capacity in the NGOC (although NGOC is not itself an Armenian NGO), and UMCOR is supporting the further development of Mission Armenia. Among the U.S. NGOs, only SCF is not working with or financially supporting an Armenian NGO.

F. Management Issues

1. Mission Oversight

The PADCO contract appears to have incorporated the most burdensome oversight requirements (for both the contractor and the Mission) of traditional USAID contracts and of performance-based contracts. Like traditional contracts, it requires USAID approval of work plans, scopes of work, proposed consultants, reports, and a host of other actions. Like performance-based contracts, it requires a formal semi-annual review of performance against targets.

Mission oversight of the NGO activities is also extensive. Interviews with the NGOs indicate that Mission approval is required of the NGOs' selection of participating communities and of specific activities. For example, although the Mission approves AAA/NGOC's grant selection process and criteria, it also reviews and approves each grant. In part, this reflects a Mission decision to utilize cooperative agreements rather than grant agreements, although the assessment team believes that cooperative agreements can be managed with less USAID involvement if the Mission desires.

The degree of Mission oversight has implications for the number and types of Mission staff needed. Mission officials indicated that Mission staffing is not sufficient to oversee the complex STP portfolio. The assessment team could not determine the extent to which this concern results from the oversight roles outlined above or the degree to which the issue might be resolved with changes in managerial roles.

2. The PADCO Contract: Focus vs. Flexibility

The PADCO contract not only identifies objectives, it lays out a fairly specific five-year implementation plan. That plan or blueprint is made more rigid by turning its major elements into contract deliverables. Although the contract has been amended several times to reflect changes in priorities and unexpected developments, the amendment process is lengthy and time-consuming.

PADCO and the MOH³⁹ have distinctly different views about the effects of incorporating that blueprint into the contract. From PADCO's perspective (and perhaps from the CTO's), the plan keeps the program focused. From the MOH's perspective, the contract and its blueprint are too rigid, either preventing PADCO and USAID program managers from adapting to a changing environment or affording them an excuse to say "no" to MOH requests.

The tension that this issue has created between PADCO and the MOH is exacerbated by issues within each organization. On the PADCO side, these include some friction between the members of the consortium and recruitment difficulties. Within the MOH, the small staff and the number and complexity of issues make it difficult to keep pace with the need to run the Ministry and simultaneously introduce change. Further, there are various factions or groups within the Ministry, making it difficult to build sufficient consensus to develop viable action plans for reform. MOH officials sometimes fail to see the value of technical assistance, believing that they already possess the skills and understanding to be effective reformers. They would thus prefer to see USAID resources expended for commodities and construction or to cover shortfalls in budgetary resources.

3. Pilot Projects vs. National Implementation

A number of the assessment team's interviewees, including senior officials at both the MOSS and the MOH and some people outside of government, expressed some frustration with USAID's practice of testing and demonstrating new ideas and approaches and then leaving them to the GOAM, the WB and others to implement nationally. There is a concern, first, that without USAID assistance in nationwide implementation, momentum gained through STP will be lost, and nationwide implementation may never occur. Second, there is concern that the Armenian public, reading about tens of millions of dollars that USAID is providing for health care and social sector reform and not seeing tangible results, will conclude that the money was stolen by corrupt Armenian government officials. The interviewees expressing these views urge USAID to focus on fewer reforms and to carry them through to completion, meaning nationwide implementation.

Several specific recommendations were offered. In STP's programs with the MOSS, the priorities for national rollout appear to be the PN and Integrated Social Service Centers. In the MOH, the priorities appear to be the MIS and HIS systems and the introduction of family medicine.

4. Staffing of U.S. Partner Organizations

The assessment team met with the staff of all of the U.S. partner organizations and was generally impressed with their knowledge and commitment.

PADCO has assembled a very strong team of expatriate and local staff, particularly for the work in the social sector. One area of concern is the difficulty that PADCO has experienced in providing appropriate resident health advisors. The person who initially served as the lead person on health reform activities

³⁹ As this issue did not arise in discussions with MOSS officials, the assessment team believes it is not an issue with respect to reforms in social insurance and social assistance.

was replaced after one year, a period during which little was achieved. Reportedly because of difficulties in recruiting a health economist experienced in health reform issues, the program has split health responsibilities among several individuals. Although the present health staff bring important assets to the program and have succeeded in moving forward on a variety of activities, activities in health appear more fragmented, and the program continues to miss the leadership and vision of a senior health reform expert.

5. Collaboration Among the U.S. Partners

STP's structure has brought together a wide variety of U.S. organizations, each with its own unique vision, with years of experience and with well-established operating procedures. STP has not required that all of these organizations work together harmoniously. Each of the NGOs, as noted above, works quite independently.

However, STP has required that most of the other (non-NGO) U.S. partners work collaboratively to achieve program objectives. These include PADCO, Abt Associates, AIHA, MACRO, Counterpoint, Carelift, PRIME II, and QED. The evidence suggests that effective collaboration has been difficult to achieve. There have been conflicts between the prime contractors and sub-contractors and among sub-contractors, and these have been difficult to resolve.

Many of these conflicts arose not from lack of goodwill on both sides but from different development priorities and different operating styles. This is particularly the case in trying to match up consulting firms (e.g., PADCO and Abt Associates) with organizations such as Carelift and AIHA that depend on a high degree of volunteerism. Expecting groups based on donated goods or services to respond like contractors, providing specific types of equipment or services at a specified date and place, can be difficult. On the other hand, such groups can generate other benefits (e.g., encouraging bottom-up planning, building support in the U.S.) that are of considerable importance. However, collaboration between these different types of organization is difficult for all concerned.

IV. Conclusions

A. Improving Armenia's Social Safety Net

Reform of Social Insurance and Social Assistance

- *STP has contributed to the achievement of considerable progress with respect to establishing the foundations for sustainable pensions and poverty benefits.*
 - Important laws have been passed on first reading.
 - Government capacity to analyze, plan and monitor social insurance and social assistance systems has been enhanced.
 - Information systems have been designed and are under development.

Case Study

Collaboration between Carelift and PADCO

Carelift acquires medical equipment donated in the U.S. and provides that equipment to medical institutions in Armenia and in other countries. Shipment of any piece of equipment is based upon demand from a reputable institution, often as part of a USAID program. Carelift's service package includes procurement, rehabilitation, shipment, installation, training in operating the equipment, training in maintenance, and monitoring use.

Under STP, Carelift's role is to support the reforms introduced by PADCO. PADCO has asked Carelift to provide equipment that supports PHC in Vanadzor Polyclinics 1 and 4. This demand does not match well with Carelift's supply of equipment, much of which comes from tertiary care facilities. Carelift is frustrated because it cannot supply that equipment which it believes would strengthen Armenia's referral system. PADCO is frustrated by the difficulty it sees in trying to get the full complement of PHC equipment and supplies it needs. Further, in providing equipment to Polyclinics in Vanadzor, Carelift was asked not to provide the equipment directly to the facilities, since PADCO wants to hold it for family group practices not yet formed. This delay, reasonable to PADCO, disrupts Carelift's operating procedures, putting into abeyance its normal installation, training, maintenance and monitoring operations.

- Public information campaigns and capacity have been developed.
- *STP has taken steps to improve the efficiency and effectiveness of the GOAM in providing social insurance and assistance.*
 - Improvements in the targeting of poverty benefits have been achieved.
 - A pilot Integrated Social Services Center is being implemented.
 - The MOSS Information and Analytical Center (Nemrout) and an Office of Actuary have been established.
- *STP has made particularly important contributions to improving the government's pension system and the Poverty Family Benefit.*
- *The potential for individual and employer provision of social insurance and benefits is dependent upon the uncertain future of Armenian financial markets, insurance markets, and corporate governance.*
- *The momentum and effective working relationships between key STP partners and MOSS bode well for the future.* The key issue for USAID in the coming year is adequate support for the national implementation of the Personal Number (PN) system.

Reform in the Health Sector

- *STP has made significant contributions to the development of legislation, policy and regulatory reform, to the development and testing of improved information systems, and to the improvement through training of many health professionals within the health care system.*
- *Progress toward establishing the basis for an effective and efficient health care system has been modest. The results achieved by the FGPs, just now being established, will be a key determinant of future progress.*
- *If PADCO and the MOH are able to resolve differences over the steps to be taken toward reform and to increase the implementing capacity of the MOH, significant progress can be achieved in the future.*
- *The AIHA Partnerships Program, PRIME II, and MACRO programs have their own sets of objectives. These programs appear to be working as planned and are likely to achieve their respective objectives. However, these programs, while complementary to the PADCO activities, do not appear to be central to the achievement of STP objectives.* These three programs have strategies and approaches that are in most instances very different from those being implemented by PADCO. Although the efforts of Mission staff and the contractors themselves to build a consistent and coherent program have met with some success (e.g., PRIME and PADCO collaboration on physician training), these programs function largely independently of one another.

Providing Immediate Assistance to the Needy

- *By helping MOSS to refocus the Poverty Family Benefit, PADCO assistance to the MOSS helped to channel GOAM support to the most needy Armenians.*
- *NGO programs are generally well targeted and effectively provide assistance to needy Armenians.* Judged by the large number of beneficiaries, the overall impact appears to be quite significant. STP programs administered through CRS/Caritas, SCF and UMCOR/Mission

Armenia have reached thousands of vulnerable Armenian families, providing important social, health and nutritional benefits and providing limited employment opportunities. The large number of STP beneficiaries is, however, only a fraction of the needy. Fortunately, there are many other programs that also provide assistance.

- *U.S. NGOs have high overhead expenses compared with local NGOs, a fact that underscores the desirability of strengthening Armenian NGOs.*
- *UMCOR's Student Cafeteria appears to be among the least well targeted and least cost-effective of the NGO programs.* As indicated above, the assessment team questions whether this program targets the most needy and the cost-effectiveness of the delivery method.

B. Implementation and Sustainability

Social Insurance and Services

- *The willingness and ability of the government to provide adequate resources to implement nationwide systems that are being developed and piloted is uncertain, including information systems, the Personal Number system, and Integrated Social Service Centers.* Although the MOSS, the National Statistical Service and the Securities Commission are enthusiastic about the reform program and desire to maintain its momentum, it is not clear that the financial resources to do so will be available.
- *The ability of the government to maintain facilities and to sustain all the new information systems is uncertain.*

NGO Programs

- *STP's NGO programs will be sustainable only with continuing support from the government, donors or the local communities.* NGO social and health programs are almost never sustainable without external support.
- *Using NGOs to test new service delivery mechanisms is probably effective only if NGOs are expected to be the users of the resulting information.* There is little evidence that government, donors or contractors pay attention to NGO experiments or pilots.

C. Integration

- *STP's integration of the work on social sector and health sector reforms has been rewarding.* Both sectors benefit from information systems that are consistent and can be linked, STP's assistance in the development of a consistent legal framework, training in common skills, and use of the same survey information.
- *The integration of the social sector and health sector work has complicated management and may have contributed to the somewhat limited progress in the health sector.* Creating and managing an effective team to work on both sectors has proven difficult for the PADCO consortium, as has dealing with two Ministries with different needs and styles. The increased complexity of the management structure within the program has also placed a burden on the subcontractors. These factors appear to have contributed to tensions that exist among several of the partners. It is, of course, impossible to know how things would have been different if an alternative organization of technical assistance had been employed.

- *Except for the various institutions working under the PADCO contract, the U.S. partners under STP function largely independently of one another, as do the MOH and MOSS. The lack of integration of these institutions does not appear to have adversely affected the ability of partners to implement their own programs, but there is little evidence of synergy resulting from putting the various contractors together under the common STP umbrella.*

D. Linkages

- *There is little integration between STP's macro and micro partners or program elements. STP's NGOs tend to work in isolation from the macro partners (the GOAM, PADCO and other contractors) and from each other.*
- *A number of the programs do test innovative models or program elements that might provide valuable lessons about cost-effective methods to deliver social and health services. Although it is too early to indicate how valuable the lessons learned from these pilot efforts will be, there is reason to question whether the GOAM or others will be willing or able to finance replication of most of the NGO models. There is little evidence that the NGO activities are perceived as experiments in alternative delivery mechanisms, which raises a question as to whether the lessons that they may generate will be learned.*
- *Building Social Partnership. STP has supported some small efforts to encourage collaboration between NGOs and government, but these do not appear to have had a significant effect on the development of Social Partnership. Although STP's NGOs often establish excellent relationships with marz-level and local government, the relationship between NGOs and the government ministries at the central level is typically not close. Senior officials at both MOSS and MOH have urged greater collaboration from NGOs.*
- *STP's contribution to developing viable Armenian NGOs has been modest. The exceptions to this statement may be Caritas and Mission Armenia. In terms of developing other NGOs, NGOC training and small grants are presumably having a positive effect.⁴⁰ However, the dearth of money available from STP or elsewhere to give the Armenian NGOs an opportunity to actually implement something limits NGO capacity growth.⁴¹*
- *The NGO programs supported by STP are most appropriately considered humanitarian assistance rather than development programs. Some of the programs, however, have a social or economic development component. CRS and UMCOR school feeding programs may have a development impact if they further the ability of children to learn. The CRS and SCF programs' civic action and community development aspects may strengthen communities' abilities to take responsibility for their future well-being.*

E. Management Issues

USAID's Oversight Role and Implications for Staffing

- *Given the limited number of staff positions and the management processes employed, Mission personnel have been stretched to deal with the large number of actors and the complexity of the STP program. Mission staffing is limited for the size and complexity of the program. However, the difficulty the staff feels in managing the program effectively also reflects the Mission's high*

⁴⁰ The evidence about the number of courses and participants that the team reviewed are not adequate measures of increased institutional capacity.

⁴¹ The assessment team did not have the opportunity to review what other USAID NGO development programs are offering. Its conclusions are thus based only on a review of what is occurring under the auspices of STP.

level of process oversight. USAID personnel review and approve a very large number of reports, documents, and spending decisions included in previously authorized work plans and budgets. These processes slow implementation and divert the attention of Mission personnel from more important tasks, e.g., building teamwork among the Partners and assessing progress toward the achievement of longer-term goals.

- *USAID technical oversight of contractor activities is limited.* USAID technical oversight is difficult when the work involves areas in which it is extremely difficult to recruit Mission staff. The availability of an outside expert (e.g., pension advisor Denise Lamaute) is extremely useful to provide an independent expert view of progress. Having a comparable expert in social assistance and health reform would assist the Mission to make informed judgments on key issues such as proposed changes in the scope of work.⁴²

The USAID-PADCO Contract.

- *The PADCO contract is overly rigid, with too many deliverables.* The number of deliverables has inundated the MOH, which feels at the same time that the program is not responsive to its changing needs. The assessment team believes that in an undertaking as complex as social sector and health sector reform, it would be appropriate to build more flexibility into the contract for technical assistance services.
- *The experience of the PADCO contract suggests that contractors and organizations that rely on voluntary contributions do not mix well.* Despite the best of intentions, collaboration between such organizations is extremely difficult and probably does not warrant the effort.

MOH Implementation Constraints

- *The MOH appears not to have the capacity to implement the number and variety of recommendations produced through the PADCO contract.* Although the MOH has some very competent and energetic personnel, their numbers are limited.

F. Decentralization

- *STP has supported the GOAM stated policy of decentralization by working with marz governments in those marzes selected for pilot activities. However, the program does not appear to have had a significant effect on Armenia's decentralization process.* Decentralization has particularly affected the health sector, where institutions around the country now have considerably greater autonomy. However, the GOAM has not backed up its policy of decentralization with budget resources, so it has been difficult for local and regional governments to undertake activities on their own.

G. Program Gaps

- *Employment and labor market programs.* An important gap in the STP social sector reform program is the lack of programs or initiatives concerned with employment, unemployment and the labor market.
- *Social services and social workers.* The GOAM offers few social services and has few trained, professional social workers. STP has provided no support to development of social services and

⁴² For information technology projects the mission acquires this outside expertise and review by submitting IT project descriptions to the USAID Bureau for Management, Office of Information Resource Management (M/IRM) for review and approval for all projects with a life-cycle cost of at least \$100,000.

only modest support to the training of social workers. There are employees throughout MOSS (especially in the local offices) who deal directly with clients and who provide some services that a social worker would carry out. MOH nurses visit homes to provide services and to assess needs, without training to identify non-medical problems that could be addressed. Training in social work techniques for these and other Armenians in the public and private sectors would make the social safety net more effective and efficient.

- *Other important gaps in the social sector program include:*
 - Lack of involvement of the Ministry of Finance and Economy;
 - Lack of attention to income distribution.

V. Recommendations

A. The PADCO Contract

- *USAID should exercise its option to extend the PADCO contract by two years to permit the contractor to continue its activities in the social sector.* PADCO's activities implemented jointly with the MOSS are progressing well, and relationships are strong and effective. Changing contractors or personnel at this time would be disruptive and impede progress.
- *The extension of PADCO's health sector program should be contingent upon (1) the satisfactory resolution of the current difficulties between the MOH and the contractor and (2) the key parties (including USAID) being satisfied that the technical assistance provided will lead to concrete actions, i.e., that the MOH will have the interest and capacity to implement the programs to which PADCO is contributing.* As indicated above, progress in the health sector has been slow, and relationships between the contractor and the MOH are strained. Resolution of these difficulties may require changes in contractor personnel, modifications in the contractor's scope of work and deliverables, changes in organizational relationships, and changes in the methods of communication and collaboration between the contractor and the MOH. The assessment team believes, for example, that it would be desirable to reduce the number of activities in the health sector and focus management and financial resources on making the FGPs successful, developing and implementing the HMIS, and a few other initiatives. With respect to organizational relationships, the team recommends (and believes that action has already been taken) that all ASTP consultants and their scopes of work be vetted with the MOH prior to their initiating work. These parties are currently trying to resolve their differences, and a much stronger program may emerge. USAID must be an active and flexible partner in the resolution of these issues.
- *Take steps to increase MOH capacity to implement the contractor's recommendations.* USAID, PADCO and the MOH might consider (1) having the contractor provide additional hands-on assistance with implementation activities and (2) having the contractor place full-time resident advisors (preferably Armenians) in several key MOH departments.
- *Strengthen the PADCO health team, recruiting if possible a senior health economist.*
- *To make FM more acceptable within the Armenian medical community, recruit a respected Armenian physician who is supportive of FM to provide leadership to the curriculum development and training programs.* The addition of this physician not only would provide valuable insights into improving the program but s/he would help to orient foreign experts and make them more effective.
- *Ensure the harmonization of the various efforts to train Armenian physicians in FM.* It is important that the various groups developing FM training curriculum meet and come to a consensus on the program basic elements.
- *Consider options for increasing the incentives to the polyclinic directors at pilot sites to obtain their support for the program.* It has already been demonstrated that the lack of support from these individuals can disrupt the important work being undertaken. Obtaining the cooperation of clinic directors is, in fact, one of the program elements that the pilots are testing and that will need to be part of any longer-term roll-out plan.

B. NGO Programs

- *Continue to support cost-effective NGO programs that provide services to the needy.* Until Armenia's economic growth accelerates and the unemployment rate falls, large numbers of Armenian families will remain highly vulnerable. USAID support through NGOs is effective and very much appreciated. At the same time, USAID might wish to monitor more closely other sources of humanitarian assistance, particularly from the diaspora, to determine if/when relief assistance from those other sources adequately meets the critical needs.
- *Do not overburden NGO programs with too many objectives.* The use of NGOs to find and test new social and health service delivery mechanisms that might be employed by government has not proven very productive and should probably be dropped from future programs.
- *Continue and redouble efforts to strengthen Armenian NGOs.* The assessment team recommends that a condition of any assistance to a U.S. PVO be that it incorporate a serious component directed toward the development of one or more local partner organizations. This component would include a time-phased plan to bring that organization to the level at which USAID would consider providing grants directly to it.
- *Use NGOs to test innovative service delivery mechanisms only if NGOs are the intended users of the information generated.*

C. Mission Management

- *In future Mission contracts and cooperative agreements, to the extent permitted by current policy and regulation, provide more discretionary authority to the recipient, limit prior Mission approvals, and hold contractors and grantees responsible for results.* These steps would reduce the workload of contractors, grantees, and USAID staff and increase the focus on achieving impact.
- *Provide more technical oversight of reform activities.* Given the dearth of experts in pension, social assistance, and health reform and the difficulty in recruiting full-time staff, the Mission should utilize intermittent consultants for this purpose.
- *Avoid programs that require active collaboration between different types of organizations (e.g., contractors, organizations that rely heavily on contributed goods or services, and NGOs).* STP has demonstrated that these organizations do not work well together.

D. Implementation (Roll-out)

- *USAID, the World Bank, the Ministry of Finance and Economy, and the MOSS should clarify and guarantee adequate financing of the costs of the national implementation of the PN system and of personal social insurance accounts over the next five years.* This should include capital costs, start-up costs and operating costs.
- *USAID should discuss with the World Bank the establishment of conditionality that would ensure that the GOAM does not cut the social and health sector budgets, undermining the reforms being put into place.*

E. Priorities for Future Programming

- *The Mission should incorporate employment and labor market programs into future STP programs.*
 - STP should monitor employment programs and the function and adequacy of unemployment benefits. The role and targeting of unemployment benefits should be considered jointly with pensions and social assistance.
 - The unemployment information system should be upgraded and linked with other social insurance and social assistance databases.
 - STP should provide support for active labor market programs such as job training/retraining and job placement services.
- *The Mission should consider the development of training programs for social workers as a component of STP, offering such programs to a wide variety of public and private sector personnel dealing with social and health services.* Although there are few people identified as social workers, there are many who are carrying out social work and who would benefit greatly from theoretical and practical training.
- *Using the PADCO contract, the Mission should assist the MOSS to develop additional ISSCs.* One ISSC is not an adequate test of that concept. ISSCs should be piloted in marzes other than Lori, where the one current ISSC is being piloted.
- *The Mission should explore the possibility of developing new ISSCs within underutilized MOH polyclinics.* With excess space available in MOH polyclinics, sharing these facilities with the MOSS could prove attractive to both Ministries.⁴³ The integration of social and health services is unlikely to occur from the top, but might occur spontaneously from the bottom if services were housed together. Collaboration between those providing these services would likely make both more cost-effective.
- *The Mission should consider an expansion of Mission Armenia's integrated social and health service model now being tested.* The Mission Armenia model potentially has valuable lessons to offer to government and to other NGOs offering social and health services.

⁴³ A senior MOSS official has indicated probable MOSS support for this idea

ANNEXES

- A. STP Evaluation Scope of Work**
- B. Contacts**
- C. Tables**

ANNEX A. Statement of Work

Armenia -- Social Transition Program Evaluation

I. Objective of the Evaluation

The Social Transition Program (STP) being implemented in Armenia since 2000 is ambitious and complex. The program design was based on several years of extensive analysis and design, and attempts to combine the efforts of the Government of Armenia (GOAM), USAID, other donors and a number of implementing partners in carrying out major reforms of the social benefits and services systems while simultaneously providing direct benefits and services to selected populations. Lessons learned from the integrated approach being taken by Armenia for health and social sector reform could be of great value to the many relatively small Eastern European and Eurasian countries still facing significant work to be done to complete their transitions.

Evaluation of the STP is being done now to inform decisions that must be made on program implementation over the coming months (including exercising the PADCO options and determining follow-on activities after the performance period of the micro elements of the program expire), and as an input to the new USAID country assistance strategy for Armenia to be completed in early 2003. This evaluation is intended to examine how the original concept and assumptions underlying this program have held up over nearly two years of implementation, and to identify changes and adjustments that would improve the likelihood of this program achieving its objectives. The evaluation design assumes that there is adequate information available on the performance of the major implementing and technical assistance partners to allow the evaluation team to focus on critical issues of integration, linkages and synergies in the original design. The evaluation will also examine how well targeting mechanisms are applied in this program, (i.e., if the most vulnerable populations have been targeted; if the different models under this program are working; if these models are appropriate and cost-effective, etc.).

The evaluation is to be carried out by a team of contracted experts, working in close consultation with representatives from USAID staff, other donors, and GOAM officials. The Statement of work that follows identifies the services required of expert contract team members.

The Mission has also scheduled a re-assessment of the overall Armenian Health Sector to better understand the available information on the status of the public health, institutional capacities, and the needs for future technical assistance. This Health Sector assessment is anticipated to be completed in the Spring of 2002 with the report being made available to the contract evaluation team reviewing the Mission's integrated Social Transition Program strategic objective.

II. Background

Discussions on the need for a social reform program to move USAID/Armenia toward development of sustainable social and health systems began in 1998, advancing in 1999 to an initial proposed strategy to link longer term reforms with immediate (humanitarian) assistance. Since 1992, USAID/Armenia had concentrated upon the provision of humanitarian services and supplies and the new strategy recognized the lack of sustainable progress in breaking this reliance. Since 1995/96 USAID and other donors have shifted from humanitarian activities to development or "bridging" activities to boost the economy, while helping people sustain themselves. However, the shift towards development activities was too rapid, leaving many people still vulnerable. As a result, the new strategy included more humanitarian assistance components at a micro-level, which is reflected in the STP.

The shift toward development was reflected in the new strategic objective 3.2 proposed in the March 1999 Country Assistance Strategy prepared by USAID/Armenia. The Strategic approach for what has

been reassigned as SO 3.4 was expanded over the remaining months in 1999 and the Mission prepared a request for proposals for the award of a performance-based contract for structural reform of the social insurance and assistance activities for GOAM combined with activities for health sector structural reform in finance, management and service delivery. In addition, the Mission issued a request for applications for grants to provide services to the most vulnerable in selected regions of Armenia.

In August 2000, the Mission awarded the performance-based contract for the macro structural reform and health sector restructuring activities to PADCO. Cooperative Agreements were also awarded to Catholic Relief Services (CRS), the United Methodist Committee for Relief (UMCOR), and Save the Children to provide various direct services, most specifically focusing on nutrition, health, and short-term work opportunities. A follow-on award to the Armenian Assembly of America (AAA) was made to continue the operations of its NGO Training and Resource Center to provide support and capacity building for NGOs working in the health and social sector of Armenia.

Other elements of the Mission's health portfolio were also captured under the Social Transition objective. These include the American International Health Alliance (AIHA) partnership program, PRIME II working on reproductive health, and Macro International, Inc. through its support of the recently completed Demographic Health Survey. An overview of these activities taken from USAID/Armenia's website in January 2002 is attached.

On August 16, 2000, the Ministry of Health and the Ministry of Social Security jointly signed a Memorandum of Agreement (MOA) with USAID/Armenia committing to support the STP program. As a result of the MOA, each Ministry established a workgroup to assist in evaluating the performance of the program. However, because the bulk of the activity for which they are directly concerned involves the PADCO contract, the performance evaluation of the STP project generally coincides with the semi-annual performance evaluation of the PADCO contract.

The following summary statement extracted from the RFP reflects the overall concept of the STP now being implemented:

C.II Social Transition Program Objectives

The goal of the five-year social transition program is, in the short term, to meet the immediate social and health care needs of the most vulnerable, while establishing the basis in the longer term for sustainable and effective social insurance care systems. USAID has defined social insurance systems to include unemployment, disability, health and pension systems. The contractor shall focus on providing assistance designed to meet both these long term and short-term goals.

For the purposes of this program, the most vulnerable have been defined as those not able to meet their basic health, nutrition and shelter needs. Categorization of the most vulnerable population is difficult in Armenia, due to the wide extent and transient nature of poverty. The most vulnerable are likely to include extended family households with three or more children.

Under the social transition program, the contractor shall focus on those elements of the program related to establishing the longer-term foundation for social insurance systems, while, in the short term, increasing the efficiency and effectiveness of the government in providing social assistance and primary health care and making improvements in publicly provided primary health care in selected regions. USAID will use a separate grant mechanism (to be completed concurrently with this RFP) to implement those components of the program in selected regions related to meeting immediate social assistance needs of the most vulnerable through NGOs and the private sector, and to short-term employment generation through public works. (underlining added for this SOW) A major emphasis under the contract will be on identifying, evaluating and incorporating lessons learned in activities implemented in the selected regions under the contract and other mechanisms into national level policy dialogue, capacity building and discussions on public and private sector roles and relationships.

C.III Social Transition Program Overview

USAID's five-year social transition program, of which this contract forms a part, focuses on establishing, in the longer term, the foundation for sustainable and effective social insurance systems, while meeting the immediate social assistance and primary health care needs of the most vulnerable. Health will be a major area of focus in terms of meeting immediate social assistance needs, as well as in establishing the longer-term systems for addressing the needs of the most vulnerable.

The social transition program will form the framework within which all ongoing USAID health and social sector programs (including the American International Health Alliance (AIHA) health partnership program, the Johns Hopkins University family planning / family health information, education and communication campaign, and the PVO/NGO networks program through Save the Children, CARE and ADRA) (2/17/02 *Note: This "networks program has been terminated and functionally replaced by the PRIME activity in 2001.*) will be implemented.

Due to the extent of social assistance needs, with more than half of the population living at or very close to the poverty line, USAID will integrate the implementation of this program to the extent possible with other Mission programs in local government development, assistance to the earthquake zone, micro-enterprise credit, civic education / civic advocacy and general NGO development. USAID will develop appropriate mechanisms for program coordination and sharing of information.

Programs are expected to affect and involve all levels of government, from the national Ministries to the marz to the local government and to the community level. Assistance will be provided both at the central / national level in terms of the overall policy framework, developing general governmental institutional capacity, defining the role of the government, and information systems and analyses, as well as in the regions to test new methods of providing various social services and primary health care and to expand linkages among local government, NGOs and the community. USAID has tentatively identified the regions of Yerevan, Gegharkunik, Lori, Shirak and Syunik as the areas that will be included under this program. As new methods are tested and found to work, they could be expanded to other regions as well.

The social transition program has the following four interrelated components:

1. Establishing the foundation for sustainable social insurance systems in the long term, through developing governmental institutional capacity, preparing the legal and regulatory framework for these systems and establishing appropriate information systems, including the implementation of a personal identification numbering system;
2. Improving the efficiency and effectiveness of the government in providing social assistance and primary health care, through clarifying the government's role at the national, regional and local level for the provision of social assistance and health care, restructuring the provision of primary health care, increasing the government's ability to plan, regulate and supervise social assistance and health care, better targeting and further streamlining of social assistance and health care programs, increasing the focus on public information and public awareness, and improving information systems and the capacity for policy, data and financial analysis;
3. Developing alternative mechanisms for providing social services and primary health care, through strengthening local NGO and service provider capacity, and pilot testing new approaches to addressing needs;
4. In specified regions, increasing citizens' capacity to meet their own needs, through support for a public works program that will meet basic community infrastructure needs, especially those related to primary health care and the provision of other social services.

These interrelated components will be implemented in phases, and will be closely linked with other donor programs in these areas. While this program has not been designed to be dependent on actions taken under other donor programs, it has been developed in a way to be complementary to other donor activities.

USAID expects to award a three-year contract, with the option for a two-year extension of the contract period, to implement certain components of this program. Specifically, the contractor shall be responsible for implementing activities to achieve all of Component 1, all of Component 2 and part of Component 3 of the Social Transition program, as more fully described below. The remainder of Component 3 and all of Component 4 will be implemented concurrently through other separately competed grant mechanisms.

Descriptions of on-going STP activities can be found at: <http://www.usaid.gov/am/social.html>

Additional information on the STP program can also be found at: <http://www.stp.am>.

Additional information on PADCO activities can be found at: <http://www.padco.am>

Additional information on the Ministry of Social Security can be found at <http://www.mss.am> or <http://www.nemrout.am>

Additional information on the Ministry of Health can be found at: <http://www.armhealth.am>

III. Mission's Reported Progress of SO 3.4

The following summary of progress through December 2001 on the overall STP is excerpted from an internal Mission review of progress done by the SO 3.4 strategic objective team:

(1) Our summary evaluation is that the activities under SO 3.4 in CY 2001 have met expectations in terms of building institutional capacity within the GOAM, establishing the legal and regulatory framework necessary for social insurance and assistance programs to be operated in a fair, transparent, and more equitable manner which is targeted to the most vulnerable population. Substantial effort has been given to improving information management systems critical improved targeting of the poverty family benefit program (e.g., full transfer of the PAROS data base to the Ministry of Social Security, establishment of the Nemrout Information and Analytical Center of the Ministry of Social Security, institutionalizing the Household Income and Expenditure Survey conducted annually by the National Statistical Service, establishing a framework for implementation of a comprehensive health information system managed by the Ministry of Health and its affiliated agencies, and the implementation of a semi-annual survey to monitor the impacts of the social reform effort on the vulnerable populations of Armenia. Legislative analysis was conducted of both the Social and Health sectors to determine what kind of legal reforms (both legislation and normative acts) would be required to establish a suitable operating environment for social and health service delivery. Training plans were developed and initiated to improve the administration of ongoing programs, upgrade the skills of the health sector to implement the GOAM's primary health care strategy, and to do statistical analysis and long range forecasting necessary for sustainable financial operations. Service delivery programs to provide improved nutrition to vulnerable populations, urgently needed medical services, and short-term employment opportunities were implemented largely within the projected timeframes and at the level of beneficiaries targeted for CY2001.

Several obstacles were encountered over the last year that may require particular focus. Significant effort is needed to ensure that the objectives of the World Bank as well as the IMF and World Bank conditionalities of the Structural Adjustment Credits related to social reform are properly aligned. Cuts in counterpart budgets severely constrain our ability to effectively work with the institutions already plagued by limited staff capacities. Social programming in Armenia has been targeted for budget cuts at twice the average rate of the other GOAM sectors and there is some suspicion that the GOAM rationale for these cuts is that international donor assistance would make up the gap.

Below is a summary of the SO team's assessment of progress toward the achievement of each Intermediate Result.

IR#1: Foundations in Place for Sustainable Social and Health Insurance System:

- Supported GOAM (MOSS) in drafting pension reform, privacy protection, and Personal Identification Number laws that have been submitted as a package this fall to the National Assembly for adoption. Work has also begun on drafting the private pension law and addressing the regulatory issues related to a private pension program.
- Established an office of the Actuary in MOSS and assisted in licensing the World Bank Prost Model to Armenia as a first step to an Armenian actuarial model.
- Established a long-term Actuarial Science Degree Program at Yerevan State University Center. Completed transfer of PAROS and Family Benefits Program from the Mergelyan Institute to MOSS.
- Established the Nemrout Information Center as the processing center for social sector information including poverty family benefit – Center will lead development of Personal Numbering system.
- The Armenian national census conducted in October 2001 is critically important to the social programming and planning, particularly insurance program planning. Although the counting exercise was completed, there is continued concern that GOAM may not be adequately prepared to see the census through its conclusion with the dissemination of accurate population data.

IR#2: Improved Mobilization, Allocation and Use of Social and Health Care Resources:

- Promoted new health strategy for GOAM health reform implementation. The strategy has the following four pillars: 1) strengthening government capacity to implement health care reforms, 2) restructuring health care finance, 3) developing family medicine, and 4) rationalizing the use of existing health resources.
- Began the piloting of the optimization process (consolidation of five health facilities) in the Lori Marz pilot site to identify implementation issues.
- Computer specialists rebuilt the State Health Agency (SHA) software system for financial data and will have almost completed re-entering all the data for 1999 and 2000 by the end of August. (The original system developed under the World Bank Health Program catastrophically failed because of design issues).
- Provided the functional analysis for the World Bank loan financing of Polyclinic 17 construction to transform the facility into the national Family Medicine Clinical Training Center. USAID contractor will support the development of the curriculum and initial training activities at PC 17.
- In collaboration with MOH and the Dutch consulting firm TNO, completed a Health Information Systems (HIS) Plan that was accepted by the World Bank and allowed for the procurement of HIS equipment scheduled for installation on or about April 2002.
- Established an action plan to use Lori Marz as a pilot site for an integrated social service center to provide on-stop shopping for application and servicing of social programs.
- *A preliminary release of the 2000 Armenia Demographic and Health Survey data was made available to the public in February 2001, and the final report is expected to be completed in December. (NOTE: The DHS was publicly released in January 2002.)*
- An assessment of training needs of primary care and maternity hospital-based health providers was conducted in Lori Marz and Yerevan in August 2001 to lay the groundwork for training activities to be integrated into the USAID supported health reform program.

IR#3: Nutrition, Shelter and Primary Health Care Services Provided:

- Free lunches, providing around 21% of the daily caloric need, have been provided to approximately 20,000 schoolchildren in a total of 60 schools in five target marzes. In some communities, the use of local food suppliers resulted in a reported 10-12% increase in jobs in the area. Additionally, the Students' Cafeteria provided a 1400-calorie daily diet to about 150 university students. As of the end of September, 15 soup kitchens were providing the daily feeding to 750 male and 1300 female (total, 2050) disenfranchised persons.
- About 80,000 vulnerable families received seasonal food, including 9 kg of wheat flour and 4 liters of vegetable oil in all target marzes. The Noah's Ark Food Security Program met the annual target of providing agricultural inputs to approximately 3000 beneficiaries
- Primary Care Guidelines for hypertension and thoracic pain management were developed and health partnership staff trained in protocols.
- In August 2001, the second annual health fair was held in Lori Marz in conjunction with a conference on Primary Health Care (PHC) Conference, and the re-opening of the newly reorganized primary care clinic in Vanadzor.
- Health partners held several planning workshops related to coordinating disaster relief and developed a workplan to improve disaster planning within the Armavir Marz. The City Galveston plans to donate used disaster response and emergency equipment to Armavir as part of its sister-city program.
- UMCOR's Community based health care activity has included mobile medical teams servicing 8 remote villages in Gegharkunik marz, benefiting about 5000 people. Expansion to 14 additional villages in Lori marz is anticipated soon. Some 12 communities in 3 marzes are working on the development of new Medical Insurance Funds to support local pharmaceutical needs. To date, approximately 250 community health care workers have been trained in areas related to childhood illness, infection disease, and acute respiratory disease. Mission Armenia has provided approximately 9000 home and community health care visits to assist the most vulnerable population with their health needs.

IR#4 Short-Term Employment Available in Selected Regions:

The SCF Public Works project focuses on creating immediate short-term job and income generation opportunities for the most vulnerable in selected marzs of Armenia. Thus far, eleven projects have been implemented employing some 1970 people and benefiting an additional 20,000 community members with infrastructure improvements like school and water system rehabilitations.

IV. Scope of Work:

This evaluation is intended to examine how the original concept and assumptions underlying the STP have held up after nearly two years of program implementation, and to recommend changes, adjustments or restructuring that would improve the likelihood of this program achieving its objectives. The original design of the SO 3.4 STP project was based on assumptions regarding the:

- ability of the GOAM and in some cases, private sector and NGO entities, to carry out significant reforms in the social sectors dealt with by the STP;
- capacity of these recipient and beneficiary groups to absorb resources, technical assistance and other guidance provided by donors, and implementing partners;
- ability of the donors to effectively manage and deliver the assistance called for in the STP;
- ability of the implementing partners to achieve the objectives and produce the outputs they have committed themselves to under their various contracting and assistance agreements with USAID; and

- need to move toward more sustainable types of social assistance and away from externally provided humanitarian assistance.

The evaluation team needs to examine these and other assumptions embodied in the STP and see how experience since 2000 has tested them. The evaluation team is to carry out a thorough examination of the success of the STP in translating its complex approach to reforming the policies, institutions and regulations that govern social benefits and health services in Armenia into practice.

This shall involve at least the following tasks:

1. Carry out a careful review of the documents available on the origins of the STP and the considerable volume of reports, documents, monitoring information and statistics that have been generated under the program. A listing of most of these materials and copies where feasible will be provided in advance to the contractor. Some materials will have to be reviewed in Armenia.
2. Carry out interviews with responsible and informed officials of USAID and other donor agencies (including the World Bank) and implementing partner organizations involved in the STP in Washington D.C. and in Armenia to advise them of the objectives of the evaluation and obtain their views on the success of the integrated, synergistic approach being followed under the STP, as well as their views on major constraints (of all types) confronting them in implementing their agreed upon activities under the STP.
3. Carry out similar meetings in Yerevan and selected field sites with national and local government officials about their views on the STP. To the extent that is possible, meet with representative beneficiary groups and individuals to obtain their views on both the structure of the program, and the extent to which they have benefited from the program.
4. Review the major coordination, communication, publicity, and lessons and information sharing components under this project between the involved parties, as well as population at large, to determine how effectively they are working.
5. Assess the value and success of using pilot approaches to promote appropriate macro policy and regulatory reforms and development activities.
6. Assess the value and potential sustainability of the information systems thus far developed or substantially under development under this program.
7. Assess the degree to which co-location and coordination of field activities between various STP implementing partners is really occurring and determine the extent of its value either to the implementing partners or the beneficiaries.
8. Assess the impact of integrating health reform and health-service delivery activities within the overall, multi-level, social reform structure. Have there been or will there likely be demonstrable benefits from this approach? Has this approach hindered or enhanced the timely and effective delivery of quality health services to the public at large? Has the integration impacted, positively or negatively, the reform efforts for social insurance and social assistance? Would the either the health, social assistance, or insurance component of the STP have proceeded more quickly and smoothly if it had been done separately?
9. Assess the effectiveness of the balance between the Mission's micro level and macro level programming.

10. Address the issues listed in Appendix 1 to this SOW either in the context of carrying out the above tasks, or separately.
11. Based on an initial review of background reports, data, interviews and field visits reach initial conclusions on the major issues confronted in this program by the end of the third week in Armenia.
12. Conduct an initial workshop with stakeholders and USAID partners at the beginning of the four-week evaluation period to discuss the approach being taken and establish contacts for subsequent evaluation activities.
13. At the beginning of the fourth week of in-country activity, present and discuss tentative findings and recommendations of the evaluation with representatives of the GOAM, USAID/Armenia, other major donors and implementing partners in Yerevan.
14. Based on the inputs from this workshop prepare a final draft report for USAID and the GOAM assessing the degree to which the STP is achieving its intended objectives, and making recommendations on how its likelihood of achieving these could be improved.

V. Team Composition

The Contract Team will include local experts as determined necessary by the contractor. In addition, the Contract Team will be augmented by support that may be available from USAID/Armenia staff, other donor representatives, USAID/Washington staff and GOAM officials who will provide input, feedback and consultation to the contract team. While these other members may be assigned substantive roles to support the evaluation, the contract team will be responsible for ensuring that a comprehensive report is completed covering the issues included in this Statement of Work.

Expatriate specialists of the Contract Team will consist of three senior experts who are expected to collectively cover the skill areas identified below. The Mission will make the award based on the qualifications and availability of the three expatriate personnel. If there are specific areas not covered by the expatriate members of the team, the contract firm will include local professionals with the required skills and proven consulting experience.

- **Team Leader.** A senior development expert responsible for directing the overall evaluation and managing the report preparation process. It is suggested that this position be filled by an individual who is a retired USAID Mission Director or someone with an expertise in mentioned areas, management experience, vision and stature. The Team Leader should also cover one or more of the other technical fields called for on the team so long as this does not appear to unduly distract from leadership responsibilities.
- **Social Services/Benefits.** A senior expert in the delivery of social services and benefits, preferably with considerable experience in dealing with the issues confronted in transitional societies in Eastern Europe and Eurasia. This position will be called upon to both assess the institutional and policy aspects of the STP, as well as the actual status of the delivery of social and health services in program pilot areas.
- **Social Insurance systems.** An expert in the area of pension reform as well as having a sound understanding of the issues related to private and public insurance systems (including health).
- **Social Assistance.** An expert in public assistance programs such as welfare and/or housing subsidies and coordinating services provided by private sector or NGO service agents.

- Information Technology systems. Many of the components of the STP depend on the development of automated data management systems, some of them linked, and many depending on geographically dispersed data entry and access capabilities.
- Health. A senior health expert who is qualified by academic training and practical experience to cover the full range of health policy, financing, institutional and service provision issues dealt with under the STP.
- Rural Works/Employment. Much of the short-term employment provided under the STP is generated by various forms of rural and civil works projects. There are serious issues about the longer-term impact of these activities if they are not linked to efforts to improve the long-term employment prospects of the employees.

VI. Local Experts

To be proposed where the three person expatriate team will not adequately cover the above skill areas. Additionally, it is anticipated that the contract team will include local expert support to ensure that the conclusions and recommendations are provided within an appropriate context of Armenian's operating institutions.

VII. Other Evaluation Participants Expected

USAID will attempt to provide substantive input and consultation support for this evaluation from knowledgeable staff from its own mission in Armenia, our Washington Office, other donor agencies who are supporting activities that are linked with or supportive of STP activities (particularly the World Bank), and appropriate Government of Armenia officials. Such support shall not include any responsibility with respect to the preparation of the final evaluation report itself. USAID/Armenia will rely upon the contract team to provide supporting documentation for all final conclusions and recommendations as part of its required deliverables.

The amount of consultation time will largely be a function of staff availability and competing urgencies, however, USAID will emphasize the need for increased consultations during the last two weeks of the evaluation period when it is expected that deliberations on the outcome of the evaluation will take place.

VIII. Reporting and Liaison Responsibilities

The contract team will be responsible to James Vandebos, the Office Chief for the Democracy and Social Reform Office. The day-to-day manager of this activity for USAID/Armenia will be Marshall Fischer, the Social Sector Specialist in the DSRO.

IX. Evaluation and Reporting Schedule

The following reporting schedule and output requirements are based on a nominal workplan which the contractor may modify in their proposal. Any modifications must be explained and justified in terms of how they will improve the evaluation process.

Proposed Schedule:

Week 1	2 –3 day team mobilization and briefings in Washington, D.C. with USAID, the World Bank and home office representatives of the key implementation partners.
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Week 2	Arrival in Yerevan. Initial briefing/meeting with USAID and GOAM officials. Round of meetings with relevant government agencies, implementing partners, and other donors.
Week 3	Field visits to provide an orientation for the evaluation team to conditions in Armenia and a brief introduction to selected STP activities, counterparts and field staff.
Week 4	In Yerevan. Follow-up meetings, data collection and analysis. Formulation of initial evaluation conclusions
Week 5	Begin with full day workshop to present major conclusions and recommendations to USAID, other donors, the GOAM, and implementing partners. Remainder of the week in incorporating outcomes of workshop and completing draft report prior to departure from Armenia.

The team will provide USAID/Armenia with ten hard copies of its draft report, which will not exceed 50 pages in length (single spaced) excluding attachments, and electronic copies (in Microsoft Word) of as much of the report material as is practicable.

USAID will provide comments on the report to the Team Leader within 15 days after receipt and the contractor will submit 12 copies of the final report (as well as an electronic copy in Microsoft Word) within 20 days after receiving USAID's comments. USAID will take the responsibility for the extent to which it will solicit comments from other parties involved in the overall STP and incorporate these into the comments submitted to the contractor.

X. Special Considerations

As noted earlier, the team members provided by an institutional contractor will work as part of a larger evaluation team. Care will be taken in the selection of the contract firm to provide these services to ensure that there are no direct competitive conflicts with the contract firms carrying out the core activities under the STP.

XI. References

- Summary document on current situation in Armenia (political, economic)
- USAID/Armenia Country Assistance Strategy 1999 – 2003
- Concept Paper for the Social Transition Program, 12/99
- Original RFP and RFA for the Social Transition Program
- Scope of Work from the PADCO Contract
- Scopes/Proposals for NGO components
- Quarterly reports of STP Partners
- Current Status summaries on overall STP
- GOAM – USAID MOU on the STP

APPENDIX 1

Issues to be dealt with in the Evaluation:

- ◆ Does the overall Social Transition Program (STP) implementation appear to be meeting the original design concept of the Strategic Objective (SO 3.4) given the existing operating environment in Armenia? What are the prospects for achieving the anticipated results? Are design modifications necessary to improve these prospects and/or in view of the existing operating environment? Please specifically address any concerns and/or specific strengths for each of the following:

Effectiveness of the linkages between policy reform activities and service delivery improvements in the social assistance, social insurance and health areas,
Balancing long-term reform activities with immediately needed short-term impacts, and
Support to the health sector provided by the social transition framework.

- ◆ Is the integration of social insurance, social assistance and health reform activities and anticipated results mutually reinforcing or does combining these reform efforts raise any specific issues or concerns?
- ◆ Is the mix of micro level support and macro structural reform appropriately balanced? Can linkages between these kinds of activities be better established?
- ◆ What are the management concerns or issues within the current STP design and operating environment for each of the following organizations:

USAID/Armenia,
The GOAM,
The implementing partners,
Local governments in the pilot and field sites?

Please examine this question in terms of institutional capacity, staffing, financing and other relevant factors.

- ◆ What is the likelihood of the GOAM being able to effectively implement and sustain the reforms being sought under the STP? What are the relevant issues and/or concerns with respect to the GOAM's existing staffing and funding constraints?
- ◆ How has the quality of the overall performance of the program been affected by the ability of the STP partners to work within the program design criteria and affected movement toward the anticipated results of the SO? Please provide specific examples for each of the following current stakeholders for the program:

USAID/Armenia Mission
The GOAM, at national and local levels
Indigenous private sector counterparts (including NGOs)
PADCO
USAID/Armenia NGO partners (including AAA-NGOC, Save the Children, Catholic Relief Services, United Methodist Committee for Relief, American International Health Alliance, Prime, and any others which might be operating at the time of the evaluation.

- ◆ How has STP's emphasis on decentralization of many aspects of the program affected program performance and prospects for meeting the anticipated results?

- ◆ Are resources, including program funding and staff, currently planned for the STP adequate for achievement of the goals and objectives of the program?
- ◆ Are the areas and approaches to reform undertaken by STP sustainable by the GOAM?
- ◆ Are there critical gaps in the kind of activities being supported by USAID or other donors that are necessary to meet the anticipated results of the strategic objective?
- ◆ How has the Performance Based Contract mechanism used for the PADCO activities affected the overall STP performance? Does this mechanism represent a quality management tool for USAID/Armenia considering the administrative requirements necessary on the part of both USAID and the contractor for its implementation?

ANNEX B. Contacts List

USAID/Washington

William Douglass
Denise Lamaute, Pension Reform Advisor
Erin Nicholson, Caucasus Desk Officer
Diane Tsitsos, Director, Office of Program Coordination and Strategy, Bureau for Europe and AsiaForest
Duncan, Health Development Officer
Paul Holmes, Regional Health Advisor-JHU

USAID/Armenia

Keith Simmons, Mission Director
Carol Payne Flavell, Deputy Mission Director
Marshall Fischer, DSRO Team Leader, COTR Social Transition Program
Nara Ghazarian (Responsible for UMCOR, CRS, Save)
Anna Grigoryan, MD
Edna Jonas, Health Advisor
Arev Movsisyan, DSRO
James Van den Bos, Director, Office of Democracy and Social Reform

Government of Armenia (GOAM)

Ministry of Health (MOH)

Ararat Mkrtchyan, Minister of Health
Tatul Hakobyan, Deputy Minister
Ara Ter Grigorian, Head, Health State Agency
Sergei Khachatryan, Director WB-PIU
Levon Yepiskoposyan, Head, Policy Department
Director and Staff of Vanadzor Polyclinic #1
Director and Staff of Vanadzor Polyclinic #4
Director and Staff of Vanadzor Polyclinic #5

Ministry of Social Security (MOSS)

Razmik Martirosyan, Minister
Ara Arakelyan, Director, Integrated Service Center, Vanadzor RELS,
Artem Asatryan, Head of Pension Security
Jemma Bagdasarian, Head of Elderly and Disabled
Gagik Bleyan, Republican Employment and Labor Service
Lola Ghazaryan, Head of Children and Families
Sona Harutunian, Head of Social Services Department
Ashik Harutyunyan, Director of Vanadzor Orphanage
Hovhannes Poghosyan, Head of Department of Foreign Relations

MOSS - Nemrout Center

Gohar Jerbashyan, Office of the Actuary
Andranik Saratikyan, Director

MOSS - Social Insurance Fund

Tigran Kirakosyan, Vice President
Robert Nadiryan, Chief Financial Officer

National Statistical Service

Hryacha Petrosyan, State Council on Statistics

Mergelyan Institute

Dr. Armen Khuchugyan, Deputy Director of the YIRCD, programmers of PARNAS and OSIRIS projects.

Securities Commission

Amalia Saribekyan, Deputy Head

Yerevan State University

Roman Shadagyan, Dean of Faculty of Mathematics

Lori Marz

Robert Kilbaryan, Health Department Head

Henrik Kochinyan, Marzpet (governor)

Tigran Papanyan, Social Assistance Department Head

Dprabak, Gegharkunik

The Mayor, school principal, leaders and members of the Parent School Partnership and other members of the community

Dsegh, Lori

The Mayor, members of the Community Action Group and other community members

Sevan, Gegharkunik

The Mayor, members of the Community Action Group and other community members

National Assembly

Viktor Dallakyan, Head, Permanent Committee for Legal and State Issues

STP's U.S. Partners**Abt Associates**

Nancy Fitch, Primary Health Care Advisor

Robert McPherson, Health Pilot Site Implementation Advisor

Lonna T. Milburn, Home Office Program Officer

American International Health Alliance (AIHA)

Barbara Bocker, Associate Executive Director and Chief Financial Officer

Donald Harbick, Associate Executive Director for Partnership Programs

James P. Smith, Executive Director

American International Health Alliance (AIHA)

Ruzan Avetisyan

Arthur Melkonyan, MD

Armenian Assembly of America (AAA)

Margarit Piliposyan

Carelift International

Aram Babayan, MD, Country Liaison Coordinator

Manuela Sieber

Catholic Relief Services (CRS),

Eric Boyle
Linda Gamova
Richard Hoffman

Counterpart

Arlene Lear, Senior Vice President, Washington, DC
Ara Nazinyan, Regional Program Manager, Almaty
Gayane Tovmasyan, Armenia Representative

Mission Armenia

Hripsime Kirakosyan, President
Grigor Kirakosyan, Executive Director

PADCO/Yerevan

Cynthia Beemish, Public Education/Media Advisor (Senior Consultant)
Charles Burge, Management Information Systems Advisor
Koryan Danielyan, Social Sector IT Project Coordinator
Gayane Gharagebakyan, Health Policy and HIS Coordinator
Artak Gharzaryan, Public Education Advisor
Gohar Jerbashyan, Expert in Social Insurance
Hovannes Kantuni, Computer Systems Advisor
Brian Kearney, Social Security Advisor
Aramayis Kocharyan, Attorney
Dean Millslagle, Health Reform Program Manager
Anna Nechai, Legal Advisor
Sylvia Rosenberg, Public Relations Specialist (Senior Consultant)
Roger Vaughan, Chief of Party;
Mitchell Wiener, Pension Advisor and Actuary (Senior Consultant)

PADCO/Washington,

Dwane Kissick, President
Susan Vogelsang, Senior Program Manager

PRIME II/Intrah

Rebecca Kohler, Country Director

Save the Children

Rezaul Hassan, Program Director
Michael McGrath, Field Office Director

United Methodist Committee on Relief (UMCOR)

Rich Bartell, Information and Training Coordinator, STP
Anahit Gasparyan, Program Coordinator;
Misak Gharagyozyan, Program Coordinator
Gohar Grigoryan, Deputy Head of Mission
Naim Ismail, MD, Program Coordinator
Marianne Tillman, Director

Other Donors**World Bank**

Dominic S. Haazen, Senior Health Specialist, Human Development Sector Unit, Europe
and Central Asia Region
Susanna Hayrapetyan, Operations Officer
Roger Robinson, , Country Manager (arrived July 29, 2002)
Owaise Saadat, Country Manager (departing)

Other Contacts

NGO Union, Vanadzor, Lori Marz
Margarita Shahverdyan

World Learning, Vanadzor
Zhirayr Edilyan

ANNEX C. SUMMARY OF MAJOR OTHER DONOR PROGRAMS, 1995-2000

Donor	Timeframe	Estimated Funding	Description
Social Insurance System Development			
World Bank – Structural Adjustment Credit (SAC) III	1999 - 2000	\$ 50 million	Policy conditionality for SAC III credit disbursement included issues related to health and social sector institutional development and policy framework; SAC IV included related conditionality.
DFID / World Bank / EU	10/99 – 2001		Support for civil service reform, including the establishment of a civil service agency
EU/TACIS	Completed	1-2 million ECU	Design of personal identification numbering system, assistance in decentralizing social security system, assistance related to employment policy and unemployment benefits
EU/TACIS	1/00 – 6/01	1 million ECU	Development of employment policy and information management system
Dutch	11/99 – 11/01	\$ 600,000	Support for development of health care financing system, included feasibility studies on compulsory / private health insurance
UNICEF / MSF-Belgium	Completed		Pilot-tested four mechanisms for health insurance in Tavush region
Increasing Effectiveness / Efficiency Of Social Assistance And Primary Health Care			
World Bank – Health Financing and Primary Health Care Development Project	1997 – 2001	\$ 10 million	Policy support for primary health care and health financing, establishment of State Health Agency, support for primary health care improvements in selected regions, training in family medicine
World Bank – SATAC	Completed by 12/99	\$ 430,000	Support for household survey, improvements in methodology for determining recipients of family benefit, operation of PAROS, implementation of family benefit system
WHO (with support from other donors)	1995 – 2001		Pharmaceutical reform (policy/regulations, financing, education, inspection, rationalizing hospital drug supply), pilot-testing of drug reimbursement system in Kotayk
Social Assistance / Primary Health Care Service Delivery			
UNICEF	1/2000 – 1/2004	\$ 4 million (+\$6 million unfunded)	Integrated management of childhood diseases, safe motherhood programs in regions where NGO partners have been working (Tavush, Yerevan, Syunik, Shirak), support for immunization, second general household survey to update 1996 survey
ECHO / MSF-Belgium	4/98 – 7/00		Reproductive health improvements – Tavush
OXFAM (with support from other donors)	1995 – 2000		Increasing access to primary health care in Vayots Dzor / Syunik regions, includes revolving drug fund, refurbishment/supplies for facilities, nurses' training, repair of water pipelines, health education
Public works			
World Bank – Social Investment Fund II	6/00 – 8/02	\$ 14 million	Improvements in community infrastructure
World Food Program	1/00 – 12/00	\$ 9.9 million (total appeal amount)	Food for work benefiting 60,000 people and take-home relief rations for most vulnerable populations (represents continuation and phasing down of earlier programs)